Qualified, *Yet Denied*: Life Experiences of Immigrant Medical Doctors *After* Denial of
Medical Recertification in Ontario

By

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A thesis submitted in conformity with the requirements
for the degree of Doctor of Philosophy
Graduate Department of Social Justice Education
Ontario Institute for Studies in Education
University of Toronto

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Abstract

Canada’s non-discriminatory immigration policy, advanced medical research, ongoing need for doctors, and promises of transitioning immigrant professionals to professional jobs, attract many doctors from developing and non-English-speaking countries. Medical doctors arrive in Canada in anticipation of a better life and to continue their medical careers. However, the majority end up in underemployed low-wage jobs outside of medicine. They risk termination of their lifelong professional identity and status after arrival in Canada. Despite passing the Canadian medical exams and meeting the requirements for re-licensure, immigrant medical doctors (IMDs) face systemic denial of access to the profession. Foreign credentials, culture, and language are identified as ongoing barriers that set IMDs apart. This study explores the professional, personal, and social impacts on the lives of IMDs who are qualified for medical recertification in Ontario, yet denied opportunities for a license to practice medicine. I briefly trace the history of the medical profession for a better understanding of how the profession was established, organized and regulated. I seek to understand how IMDs of visible minority backgrounds are viewed within the existing structure of the profession. Using a qualitative research methodology, I interviewed 15 IMDs from countries in Africa, Asia, the Middle East, Eastern Europe, South America, and
the West Indies. Participants’ motivation for continuing to seek opportunities for medical recertification, after being denied, struggles and frustrations they face as desperate need for doctors continue to exist, are revealed in this study. I make recommendations for re-imagining and adapting IMDs’ foreign skills as a valuable contribution to the patient-care delivery in Ontario’s diverse population. I provide suggestions for change to resolve the prevailing IMD problem and including more IMDs in residency training and the medical workforce.

*Keywords:* Immigrant doctors, IMDs/IMGs, Immigration, History of medicine, Medical recertification, CanMEDS, Anti-colonialism, Motivation, Governance, Social justice.
Acknowledgements

This thesis is dedicated to the immigrant medical doctors (IMDs) who have chosen Canada as their new homeland, are seeking medical recertification but feeling marginalized, discouraged, and frustrated, from the lack of support and opportunities to flourish in their new homeland. I genuinely hope this study leads to bringing about positive changes for IMDs, and especially the participants in this study for whom I am extremely grateful. Moreover, this thesis would not be possible without the steadfast and unwavering support of my supervisor, Professor Paul Olson, and Committee Members, Professors Njoki Wane and Peter Sawchuk. I thank you for your guidance, sound advice and mentoring during this entire journey. I thank my external examiner, Dr. Molefi Kete Asante, for your gracious acceptance to critique my work with an internationally renowned and scholarly lens. I thank my internal examiner, the Honourable Justice Marvin Zuker for your valuable feedback. I thank Dean Glen Jones and Professor Tanya Titchkosky for setting aside time as alternate examiners. I am grateful to you all. You have made this accomplishment a most pleasant and rewarding one for me.

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Lastly, my heartfelt thanks to the University of Toronto. I entered the doors of this amazing institution as a Clerk Typist decades ago. Through some amazing opportunities in a lifetime at this university, I am “flying” through the doors with the proud distinctions of “Dr” Cindy Sinclair, Alumni, and Ambassador, accompanied by my husband and sons who are also proud alumni of the U of T. I am immensely grateful. Thank you U of T!
Dedication

To my family:

Husband ~ John Sinclair

Sons ~ Andrew John, William James and David Giles Sinclair

Daughter-in-law ~ Julie Kuroda-Lanselle Sinclair

Future daughter-in-law ~ Amanda Jane Whitfield

And my study participants
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## Acronyms and Abbreviations

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<tr>
<td>AFMC</td>
<td>Association of Faculties of Medicine of Canada</td>
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<td>AIPSO</td>
<td>Association of International Physicians and Surgeons of Ontario</td>
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<td>AMA</td>
<td>American Medical Association</td>
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<tr>
<td>CAPER</td>
<td>Canadian Post-MD Education Registry</td>
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<td>CaRMS</td>
<td>Canadian Resident Matching Services</td>
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<td>CHRC</td>
<td>Canadian Human Rights Commission</td>
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<tr>
<td>CFPC</td>
<td>College of Family Physicians of Canada</td>
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<tr>
<td>CMA</td>
<td>Canadian Medical Association</td>
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<tr>
<td>CPSO</td>
<td>College of Physicians and Surgeons of Ontario</td>
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<tr>
<td>DIM</td>
<td>Diversity in Medicine</td>
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<tr>
<td>GTA</td>
<td>Greater Toronto Area</td>
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<tr>
<td>HRSDC</td>
<td>Human Resources Skills Development Centre</td>
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<td>IMDs</td>
<td>Immigrant Medical Doctors</td>
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<td>IMGs</td>
<td>International Medical Graduates</td>
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<td>LMCC</td>
<td>Licentiate of the Medical Council of Canada</td>
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<td>MCC</td>
<td>Medical Council of Canada</td>
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<td>MCCEE</td>
<td>Medical Council of Canada Evaluating Exams</td>
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<td>MOHL-TC</td>
<td>Ministry of Health and Long-Term Care</td>
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<tr>
<td>NAC</td>
<td>National Assessment Program</td>
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<tr>
<td>NAC-OSCE</td>
<td>National Assessment Program-Objective Structured Clinical Exam</td>
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<tr>
<td>Ob/Gyn</td>
<td>Obstetrics and Gynecology</td>
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<tr>
<td>OECD</td>
<td>Organization for Economic Co-operation and Development</td>
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<td>OFC</td>
<td>Office of the Fairness Commissioner</td>
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<td>OHRC</td>
<td>Ontario Human Rights Code</td>
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<td>OMA</td>
<td>Ontario Medical Association</td>
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<tr>
<td>RCPSC</td>
<td>Royal College of Physicians and Surgeons of Canada</td>
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<td>University of Toronto</td>
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Chapter 1
Introduction

There is only so much you can do, but when you have a family and you come to this
country for a purpose, it’s harder. It’s hard when your young children see you going out
to study or take courses weekend after weekend. Then, only this morning, my youngest
girl said to me, “Daddy, where are you going today? Are you a doctor yet?” What do you
tell your child in this situation? You can’t even be a role model to your children because
you have nothing. (Dr. Eddie, interview participant).

Like many of the thousands of immigrant medical doctors (IMDs) who arrive in Canada
every year, the speaker in this comment is a highly-trained professional. A physician with years
of education and experience, he has left behind an established medical practice to respond to
Canada’s call for doctors. He sees opportunity in Canada’s advanced level of medicine and
medical research not only for his own interests in medicine but also for contributing to the
profession and to Canadian society as a future citizen. He brings with him fluency in several
languages and expertise with a wide demographic of patients in the different countries where he
has studied and worked. He is capable, bright, and adaptable, and prepared to undergo medical
testing, examinations, and a retraining residency program to practice medicine in Canada. He
immigrated to Canada with his wife and children. His wife returns home to work temporarily to
keep her professional status in the family while he remains in Canada with their children and
tries to secure medical recertification. Several years later, he has become part of the burgeoning
population of IMDs denied and re-trying for re-licensure to practice medicine in Canada.

The Association of Faculties of Medicine in Canada (AFMC) 2012 Report shows the
estimated numbers of IMDs who met the requirements for retraining residency programs
between 2009 and 2012 and not (yet) on the path to licensure as 9,219 (Association of Faculties
of Medicine, 2012). The Canadian Post-MD Education Registry [CAPER] data shows 9,225
IMDs not born in Canada and not Canadian citizens (IMDs), plus 1,995 not born in Canada and
are Canadian citizens (CIMGs), for a total of 11,220 IMGs (international medical graduates),
who passed the Medical Council of Canada Evaluation Exam (MCCEE) between 2005-2011
(Health HR Group, Table 6, p. 11). Calculations show that 4,707 of these IMDs (1,639 Canadian
citizens and 3,067 not yet Canadian citizens) are not in the path to licensure (Table 7, p. 12).
According to a 2012 study by Jablonski, 87.8% IMDs were not able to secure retraining
residency between 2007 and 2011 (p. 12-13). Thus, only about 12% of IMDs were selected to
enter retraining programs. The Canadian Resident Matching Services (CaRMS) data also shows that almost 50\% of IMDs are repeated application to CaRMS from previous years (p. 10). In comparison to Canadian Medical Graduates (CMGs) and IMGs, while 2,761 CMGs were matched to R1 retraining positions across Canada, only 408 IMGs were matched to positions (CaRMS, 2016 R-1 Match). These numbers for IMDs represent the IMDs who meet the requirements for medical recertification, denied a retraining position and have continued to reapply.

The MCCEE exams and CaRMS application processes for IMDs are extremely costly. The pathway to licensure is complex and difficult. IMDs lose several years of employment income during their prime working years while studying and seeking Canadian medical knowledge and experience in preparation for the recertification process. In the end, despite financial costs to study and pass the exams for eligibility for retraining residency programs, these costs produce no economic outcomes or job preparation for IMDs in the workplace. While IMDs are successful in the exams and in meeting the requirements for residency programs, ethnic minority IMDs face greater restrictions gaining retraining programs based on their immigrant status (Guo, 2009; Borges, 2011), in addition to their foreign credentials, language and cultural differences (Zulla, Baerlocher, & Verma, 2008). Despite a growing shortage of doctors in Ontario and across Canada that leaves almost five million patients with no access to family doctors and other healthcare accesses (Baines, 2010; Leslie, 2015; Stickley, 2014), these qualified, yet denied IMDs are not being considered to fill the shortage gap. Rather, retraining quotas for IMGs are left unfilled (PGME Report, 2015 - CaRMS 2015 Vacant Positions). The longer IMDs wait for a retraining program, the faster they run the risk of falling into the recency-of-training deficit for recertification (HealthForce Ontario, 2016) and termination of their lifelong professional medical career, professional identity and status. While some qualified IMDs may succumb to loss of profession and status for various personal and economic reasons and fall into underemployment, other IMDs refuse to accept defeat. These IMDs persist by continuing to upgrade their skills, rewrite Canadian exams and remain competitive for a retraining program.

This study explores the life experiences of the latter group of IMDs who are denied medical recertification in Ontario and persist for the opportunity to continue their lifelong medical career. It explores, firstly, what motivates IMDs to come to Canada. It explores the professional, personal and social impacts on the lives of these IMDs during the trajectory of their
persistence to latch on to their professional career. It seeks to understand what are the deeper thoughts, reasoning, experiences, and wisdom that propel IMDs to persist with re-applying for medical recertification. It further seeks a sociological inquiry into the problems IMDs face in Canada.

I applied a qualitative research methodology to this study and interviewed 15 IMDs from countries in Africa, Asia, the Middle East, Eastern Europe, South America and the West Indies. Participants were mostly from the Province of Ontario, and more specifically from the Greater Toronto Area (GTA). This geographical restriction was due to lack of funding to support a student research project. All study participants obtained the Doctor of Medicine or equivalent degree designation from accredited international medical schools recognized by the World Health Organization (WHO). Using a theoretical framework that incorporates theories such as immigration, motivation, critical race and racism, under the umbrella of an anti-colonial framework, helps to explore the problems IMDs face under the lens of institutional dominance in the medical profession.

Throughout this dissertation, I interrogate arguments about discrimination, race, racism and institutional dominance, identified in other studies, to theorize the findings in this study. However, since my underlying goal leans towards asserting what can be done to correct a long-standing problem that has blocked IMDs from recertification opportunities, interrogating the data under the anti-colonial framework allows for a more expansive and critical exploration of the issue at hand. The anti-colonial framework enables me to explore and critique colonialism, power, dominance and control exerted over the people (Dei, cited in Calliste & Dei (2000), while I probe into how a Eurocentric British education systems and models are applicable to the colonized people (Dei & Kempf, 2006) such as IMDs. An anti-colonial framework helps to critically theorize and support arguments for change using Kurt Lewin (1946) model for resolving problems through action research. The anti-colonial framework provides a contextual base for interrogating policy and action recommendations on this very important issue that not only affects IMDs, but affect the lives of patients who are sick and do not have access to doctors.

Canada’s low birth rate and high death rate (Statistics Canada, 2016) makes it more reliant on immigrants for population stability. Its welcoming and non-discriminatory immigration policy attracts immigrants from a wide range of developing and non-native-English
speaking countries, regardless of people’s color, race, ethnicity, creed or sex (Canadian Immigration Policy, 1967). Moreover, most these new immigrants settle in the larger Canadian cities such as Toronto. By 2011, the GTA population comprised of 45.7 percent of ethnic immigrant population (Challinor, 2011).

Canada is committed to equal access to medical care (Healthcare Act, 1985) for every person. At the same time, it continues to tolerate a shortage of doctors while denying IMDs as unsuitable for retraining to fill the shortage. The government of Canada promises new immigrants democratic freedom, multicultural inclusion (Canadian Multiculturalism Act, 1985), equality and fairness to work and other opportunities (Human Rights Code, 1990). However, IMDs continue to fall short of this equality and fairness in the professional workplace and training programs. Their foreign education is unequal to the Canadian standards. Their language and culture are different from that of the Canadian medical profession.

This study offers suggestions for transitioning IMDs into the medical workforce in the Province of Ontario to sustain Canada’s promises of equality, fairness, and opportunities for all people. It offers recommendations to find new ways to capitalize on IMDs’ skills to enhance patient care to the vastly diverse patient population in Ontario. It suggests recommendations for policy changes to prevent similar misfortunes of future IMDs. Guided by action research and theory of change (Anderson, 2005; Weiss, 1995; Lewin, 1946), I also provide suggestions for the establishment and implementation of a new IMD Office to serve IMD professionals only and the establishment of a Diversity in Medicine (DIM) program as immediate steps to solve the current IMD problem, while making recommendations for long-term policy changes at the macro levels of the government and the medical profession.

In the remainder of this chapter I lay out the background of the study, followed by my personal insights and how I came to understand IMDs because of my personal journey as an immigrant from one British colony to another British colony, and my employment at the University of Toronto (U of T) Faculty of Medicine. I then address some of the major contradictions in the medical profession, Canada’s immigration policy and Canada’s claims to support immigrants, along with the continued refusal to accept IMDs in the medical profession, followed with the significance of why this study is important, research questions and definitions.
for key terms used throughout this dissertation. Finally, I provide an overview of how the thesis is organized and a conclusion.

**Background of the Study**

This study emerged from my unconscious personal observation and experience working in the medical school at the U of T. There I encountered new IMDs arriving in Canada and their excitement to go through the process of securing re-licensure to continue their professional career and make Canada their new home. I saw IMDs arrived as highly motivated individuals, ready and willing to do whatever it takes to integrate in the medical profession. Then I saw them left my office years later as very disappointed people. In today’s 21st century globalized world with advanced technology and international incentives, more people are travelling the globe looking for new and better opportunities (Coutinho, Dam, & Blustein, 2008). More people such as IMDs are taking their social, human, cultural, and career skills to new places to seek out better opportunities than those available in their home countries. The basic assumption is that people have choices in their work lives (Coutinho et al., 2008), and like other immigrants including myself, IMDs immigrate to Canada to fulfil some of their choices.

Canada advertises widely that it has a need for doctors and other medical specialists and medical workers (Services Canada, 2013). Statistics Canada (2013) reveals that in 2013, 15.5% of Canadians aged 12 and older—roughly 4.6 million people—reported that they did not have a regular medical doctor (p. 1). The Ontario Medical Association (OMA) claimed there were 800,000 people in Ontario who do not have a family doctor (Leslie, 2015). While this need for doctors in Canada is encouraging news for IMDs, as evident in this study, it has not the case. Rather, the situation worsens for IMDs. Upon arrival in Canada, IMDs are required to pass the Canadian Medical Council of Canada Evaluating Exams (MCCEEs) which are designed to evaluate IMDs’ knowledge for par at the Canadian medical graduates’ level (Boyd and Schellenberg, 2008). These exams are also offered in 500 Medical Council of Canada offices around the world as first-hand attempts to test foreign doctors’ medical knowledge for Canadian equivalency (MCC, 2016). Those who pass the exam are encouraged to immigrate to Canada in anticipation that there are jobs for them. Knowing this, IMDs come with hopeful prospects to work as doctors in Canada. The immigration process is also long and arduous. Several years of wait-time for visa processing, credential updates and verification, costs for other English tests
and other preparation for meeting the immigration requirements for immigrant status (Canada Immigration Visa, n.d.) are also very costly expenditures for IMDs. Instead of reaping the benefits of their investments after arrival in Canada however, IMDs rather face disqualification of credentials, language and culture as “foreign” to the Canadian medical system and profession.

Discrepancies in credentialing process create a huge waste and underutilization of immigrant skills (Reitz, 2001, Peters, 2012). They create a great loss to the Canadian economy and rob IMDs of many prime working years in life (Boyd & Schellenberg, 2008; Peters, 2012). Personally, I have seen the bewilderment in IMDs after they arrived in Canada and then learned of the extent of the “inferior” scale of their credentials, and the complexity of the recertification process. For some time, I thought of my personal experience as a new immigrant to Canada seeking to establish myself in a new country and the obstacles I faced. Very often as I saw IMDs left my office, I wondered how much more difficult it must be for them. They are trained professionals with many years medical education and work experience. Some have families and young dependants, and bleak opportunities for a professional life and career in the new homeland. The remainder of this chapter provides my positionality in this study and key issues from the literature that frames the situation of IMDs in Ontario, in Canada, and in the regulatory body of the medical profession.

**Understanding IMDs through my own Immigrant Journey**

Growing up in the developing British colony of Guyana and in a Hindu family, my future was defined under the colonial and Hindu thinking that a girl’s place is in the home as a homemaker and a mother, through an arranged marriage. It was my parents’ custom for their daughters to be married after finishing high school. These thinking stemmed from their religious and cultural backgrounds migrated from India to Guyana and the political influences in the colony.

Guyana was founded by Dutch European settlers in the 1700s and later taken over by the British in 1814. It was renamed British Guiana. This take over resulted in British dominance in the schools, businesses, plantations, sugar estates, government and even in the small mom-and-pop stores such as my parents’ store. We lived in a smaller village. From where I stood, there was stability in the communities and the country, in the school system and business communities. Children in uniforms walked to and from school in the hot day’s sun, looking
smart. Christian and Catholic churches were visible in the communities. I admired families passing our shop on Sunday mornings to go to the Christian church. I admired the big white homes of the British managers in the sugar estate compounds with huge green lawns and families sunbathing in the mid-day sun. Law and order enforced by the police and soldiers kept crime and corruption at bay. As early as 5:30 in the morning, men in droves would carry their lunch in shiny aluminum saucepans as they make their way to the cane fields to cut the sugar cane. They carried glittering cutlasses over their shoulders. The sharper the razor on the cutlass, the better for productivity. Other groups of men would gather the chopped sugar cane in the fields, prune the branches off, and sort them for loading onto transport trucks to the sugar factory operated by British managers. This seemed right to me because the men were working. They had a job. At the end of the week, they received a pay cheque for their productive labour, which in turn sustained their lives and their families. Our shop was busy on Friday and Saturday with women paying their bills from their husbands’ pay and stocking up on food for the next week. As far as I can remember, people were happy. Everything colonial was present in Guyana amidst calm and stability. Women’s place was in the home as homemakers and caregivers.

My parents and grandparents lived a comfortable life as shop owners. My grandparents were first-generation Hindu debentured shop owners from India, another British colony. They had great respect for the British monarchy. My father had a good relationship with the managers of the sugar estate. On weekends, he took them and their families on trips to the savannahs and showed them the day-to-day lifestyle of the people in the villages, as many colonized tend to do when under the British colonials (Memmi, 1965).

Reflecting as I write this thesis on IMDs of visible minority backgrounds and many from former British colonies, returns memories of my life under colonial rule in Guyana. My life was pleasant in one respect because my family were business owners and I lived in a comfortable home. However, opportunities for work, self-sufficiency, higher education and independence for young adults, and especially women, were rare. After I met my uncle and his wife who were both studying medicine abroad a few times, I became inspired to seek out opportunities abroad. I grew determined to move away from home and from my parents’ traditional Hindu culture and norms of marrying their daughters through arranged marriages. I searched the newspapers and other resources to seek out opportunities for moving to a foreign country. At the age of 19, against my father’s wishes of marriage, I arrived in Canada as a single woman. I arrived in the envied land
of “milk and honey” as many people from overseas believed it to be. I attended a business college after arrival and started to look for work after graduation. I did not have Canadian experience and I needed a job to survive. I had to prove to my family, neighbours, friends, and community back home that I was not a failure in Canada, as immigrants tend to feel they must do because anything less can bring disappointment and humiliation to the family.

I posted advertisements for typing jobs on supermarket and bulletin boards in the U of T area where I lived. I worked evening and mid-night shifts as a server at local restaurants for income. Then I received my first five-day-a-week day job in a stationery company packing orders for shipment, which used a punch-card system with a quota for how many orders must be completed in an hour. That was brutally rigid. I worked at a downtown law firm, but the legal terminology for shorthand and transcription proved difficult. After a good continuous search and trials at different employments, I was offered a job at U of T in the Business School. I felt welcomed at the school. I worked hard to remove my “creole” dialect to avoid labels that I was less educated or less bourgeois as Fanon (2008) describes it. The skills I learned at my parents’ shop helped me ease into over-the-counter service for students and faculty at the university. The job was good until a professor made a comment about my inability as a West Indian secretary to understand his instructions to leave a message for his students that he was sick and his class was cancelled.

Around the same time, the American Civil Rights Movement including the assassination of Martin Luther King, Jr. (History Vault, n.d.a) and the American Civil Rights Act (1964) were at its peak. It was the time when discussions were peaked about Blacks and Whites. Blacks were not allowed to ride together on the same rail car with Whites, sit in the same waiting room or theatre, or eat in the same restaurant, much less work together. It was the time when university students were getting actively engaged in the fight for racial equality, and there I was, a brown “West Indian” woman in a new country with still some creole accent (although I was on my way to losing most of the accent by this time), occupying a space in the “White” university setting that was probably meant for someone more capable of speaking and understanding Canadian English and following instructions better than immigrants (Li, 2003) such as myself. To my surprise, the students in the professor’s class took the Professor’s comments about his West Indian secretary seriously as being a racist comment. I was very uncomfortable with their action. I needed a job to survive. Instead, I found myself at the centre of a debate that I was not
particularly knowledgeable about, too scared to be identified with the claim of racism, and frankly, not interested. I reacted by making myself almost invisible and withdrew from all social activities at work and surrounding areas. I dreaded going to work as I did not want to be approached by the professor or the students. All I wanted was a job and a life in Canada. After several months of ongoing meetings, I was then called to the Dean’s office in the presence of the Dean, the faculty and students and was given an apology. Not long after, I was promoted to personal secretary to the Associate Dean in a different section of the School. I was happy with the promotion. I knew I was good at my job. I put the experience aside as a one-time-only incident and never wanted to look back at it. However, being in the building and having to cross paths with the professor, other faculty, students, and staff was awkward and uncomfortable. It was awkward because I felt blamed that for supporting the action of the students against the professor even though I did not initiate it or interested in it.

Looking back, perhaps I was in denial that racism or discrimination existed in the U of T workplace. Rather, I never actually gave much thought to these words. Neither did I question my status in a colony (Canada) as a foreigner being discriminated against. My colonial upbringing and my associations with the White Canadian families whom I met soon after arrival in Canada, lived with as a boarder and babysitter to their children, were warm and welcoming. I accepted these families as typical Canadians who are genuinely nice people. During the history of my work, I applied for other university jobs suitable to my qualification and experience. Very often I was granted an interview but after the interview I would feel like a fraud. The personnel officer would call Cindy Sinclair while searching the waiting room for a response. I would raise my hand and the response very often was with a surprise. Perhaps because the white English name did not match my immigrant look (Guo, 2009), the elements of surprise was present. With a warm hello and nice thank-you handshake at the end of the interview, those experiences would come to an end. Often, I became perplexed about the experience and later started to put my “Indian” name on my application to save the embarrassment at the interview, even though Cindy Sinclair is my name. Nevertheless, I was an immigrant, and one of color. I fall within the “codified word of people of color who come from different racial and cultural backgrounds, who do not speak fluent English” (Li in Guo, 2009, p. 40) similar to the IMDs in Canada. Rather, as Guo argues, skin color is used as the marking and social construct of who is an immigrant (Guo,
2009) and very reluctantly, I came to believe that my experiences with job interviews was what kept me at the medical school for over 25 years, a place where I was happy and comfortable.

A more recent experience, however, with a senior administrator at U of T, among other experiences that I gave a blind eye to, led me to think that the university has not yet combated racism and discrimination. I was asked to step down from a long-time volunteer position with the reasoning that the association needed to revamp and focus the association towards younger people. Ironically, other older members in the association had received various awards and honorary status for their long services. There were several unfilled positions and vigorous attempts were being made to fill these positions. One was filled with a more senior male alumnus. There were also other older members who held executive positions and actively participating in the association, but I was asked to step down. This was a hurtful, not to mention, very embarrassing. How do I explain this experience to colleagues and friends in my department of Social Justice Education (former Department of Sociology and Equity Studies)? This experience drew me more closely to my research with IMDs. It caused me to wonder how much more hurtful it must be for new immigrant doctors (of color), both males and females, who are at the peak of their professional careers, travelled across the oceans to a land for better opportunities, are welcomed as doctors, and then rejected consciously or unconsciously, as foreigners who cannot fit in the norm of the profession.

During my undergraduate education program, I studied the history of medicine. I explored the inequality and suffrages of women in the medical profession. I identified the problems of inequality and discrimination against women in a male dominated colonial structured profession and was awarded the Ontario Scholar’s Press Award for this research. As executive assistant to the Chair in my most recent appointment at the University, I worked closely with faculty and the administration on academic matters. My office door was always opened. Often students would stop by with specific or general questions. They always seemed pleased that I offered them a seat and took the time to chat and answer their questions, or direct them to the appropriate person. What I realized now that I have stepped back from this job and assumed the role of student, there is unspoken power in university offices. Stepping in a staff or professor’s office with one foot in the door and the other one outside, feels like intruding in a space of power. I wonder if IMDs’ experiences as newcomer immigrants, are similar or different. I suggest this would be a good future research study as it is missing in the literature.
There is evidence that IMDs from developing countries face systemic denial of medical re-licensure (Bauder, 2003; Boyd & Schellenberg, 2008; Li, 2000; Reitz, 2001). Their foreign credentials, culture, language, and communication skills are marked with deficiencies. This in turn, makes them unsuitable for retraining to practice medicine in Canada (Zulla et al., 2008). Concerns have focused heavily on the challenges medical schools’ programs and program directors encountered with IMDs during their retraining programs. Communication, integration in residency training, and successful completion of exams are high on the list as barriers that keep IMDs out from the profession (see Szafrań, Crutcher, Banner, & Watanabe, 2005; Hall, Kelly, Dojeiji, Byszewski, & Marks, 2004). The literature refers to IMDs as unable to integrate into the cultural norms and practices of the profession (Wong & Lohfield, 2008). Is the profession suggesting that IMDs must transfer their beings into Canadian subjects if they wish to gain acceptance and practice medicine in Canada? Isn’t Canada a multicultural country that accepts immigrants and refugees from all corners of the world without discrimination? Some have argued that the medical profession is acting as gatekeepers to keep out immigrant professionals from entering the profession (Basran & Zong, 1998), thus there are ongoing attempts to redesign tests and exams (Association of Faculties of Medicine of Canada, 2012) to make it more difficult for IMDs to meet the eligibility standards expected for the Canadian medical profession.

Canadian students spend four years in medical school, followed by two years of family medicine training or five years of sub-specialty training before they can become eligible to practice medicine. In developing countries, especially in former British colonies such as Kenya, Ghana, India, and the West Indies, where education is valued and limited to a few, and the pursuit of a medical career is a rare and exclusive opportunity, the medical training and education may seem different, but why is it so different if the model of medicine and medical education took their roots from the same British model as Canada? It is a pride and joy to entire family if their child pursues the study of medicine as in the case of my uncle who studied to be an obstetrician and gynaecologist. If the person belongs to the rich, elitist upper class echelon as has been the case in England, a doctor in the family is a stronghold in maintaining the family’s class status in society. Moreover, children who are supported by families to pursue careers such as medical doctors, are likely high performance students in school (Barro and Lee, 2001). Suggesting that IMDs from developing countries are unequal to Canadian standards because of
their foreign credential and immigrant status and forcing the majority of IMDs into assuming underemployed low-wage taxi drivers or other labourer and menial jobs (Bauder, 2003; Boyd & Schellenberg, 2008; Li, 2004; Reitz, 2001) can be very damaging to the individual and his/her family and community. To have attained the status of a professional doctor and then face termination of status and professional identity (Chen, 1999) after arriving in Canada, not because of personal ability, efforts or wrongdoings, can add unnecessarily hardships and embarrassments to the individual and their well-being.

During my visit to Ghana in 2015 for a higher education conference, which I promoted and organized, to foster international collaboration between the U of T and universities in Ghana (see Appendix A), I engaged in lengthy conversations with families and community members, including medical doctors. The pride and happiness families expressed in talking about themselves and their children and relatives who studied medicine at home and abroad, were no different from the families I am familiar with in Guyana or Trinidad and Tobago. Medical doctors, more than any other professionals, are highly respected and admired as individuals who bring increased social status to families in developing countries and other countries such as Israel, Russia, and Eastern Europe (Shuval & Bernstein, 1997). Doctors are role models and inspirations for children, younger people, older people and respected by the broader communities of patients. Some are even given regal status for helping to bring a new son and daughter into the world safely as in the case of my uncle.

In multicultural Canada immigrants are encouraged to maintain their language, beliefs, culture and other practices, but resources to support families and patients are not keeping pace with the growing diverse population needs. IMDs who bring international and intercultural resources are not being utilized to fill these needs. The IMD says good-bye to families and friends, immigrate to Canada for better opportunities in a more advanced and developed country and soon after arrival, they find themselves being barred from professional opportunities. Failing to live up to the families’ expectations when the needs for doctors are so vast is a huge disappointment to IMDs and their families. It is also a great waste of their financial and other supports and IMDs’ individual human capital (Barro, 2001).

Kwame McKenzie (2013), an immigrant doctor from England, and now the director of the Centre for Addiction and Mental Health, explained that people tend to immigrate for a better
life, for safety, and for professional reasons. Immigrant professionals with families, such as McKenzie and his family, value education. They carve out Western cultural activities to provide better educational and other opportunities for their children. McKenzie personally wanted his children to have a sound education and live in a city where there are more opportunities. During the course of my work at the U of T, I heard IMDs talked about their ambitions for themselves and their children. These stories resonated with me, but what do IMDs tell their children after they keep failing the chance for a license to practice medicine? How can they become a role model for their children? What do they tell their families back home who look up to them as the educated doctor who immigrated to Canada for a better and more prosperous life and end up driving taxis and serving coffee?

Little (2013) argues that North Americans habitually think of their culture as very different from other cultures. What he seems to be reflecting on, is that North American culture is dominant while not recognizing the Native North American culture as part of the educated society. The North American culture emerged after the British took control of the Native land and the French colony in 1763 and rule the land henceforth. Descendants of early European settlers no longer see themselves as immigrants in the land. Rather, they look to today’s immigrants as people of color from various racial and cultural backgrounds, less fluency in English and only capable of working in nonprofessional lower level jobs (Guo, 2009; Li, 2003). Hence, IMDs who are from developing countries tend to fall within this description of immigrants and ultimately judged as immigrants with foreign cultures. The question is, whose culture is foreign? Is it only the IMDs’ culture or the British Canadians living in the Natives’ land?

I grapple with these thoughts in relation to medicine and patients’ bodies. Is it that Canadians are superior to qualified persons of colour in the delivery of patient care? There seems to be an assumption that IMDs cannot understand White bodies, Canadian education and Canadian medicine. Are North American bodies superior because they are in the first world compared to patients in the developing world? Is this notion of superiority the reason for rejecting visible minority IMDs from developing countries from the profession, or is the rejection mostly to limit the number of foreign doctors into the profession to protect a superior culture and dominance? How is it that Canadian doctors can have the ability to understand or “pretend” to understand ethnic patients’ bodies and speak their language but ethnic IMDs who
have experiences with these bodies, speak English and other international languages, and educated in full or in part in a British colonial system cannot adapt and fit into the “shoes” of Canadian doctors? I tried to make sense of these questions through various theoretical lenses, bodies of literature and statistics, but as I discovered, more research is needed to explore these questions. I can, however, try to understand IMDs through the Canadian paradox in the following section.

Understanding IMDs through the Canadian Contradictions

Canada is a developed, Western, and politically safe country. It has a reputation as a land of opportunity, fairness, diversity, and multiculturalism. It has a reputation as a safe and beautiful country with a non-discriminatory immigration policy that welcomes immigrants from all nationalities, religions, and cultures (Immigration and Refugee Protection Act, 2001). As a country that relies on immigrants to help sustain its population and economic growth, Canada accepts IMDs and their families and promises equal treatment for individuals before and under the law. Canada promises the right of protection and benefits without discrimination. It promises that everyone has the democratic freedom to live and work in this country, celebrate their culture and way of life, and has freedom of conscience, religion, thought, belief, and opinion (Canadian Multiculturalism Act, 1985). It promises career transitioning for IMDs in professional employment with preparation and counselling services (Career Transitions Programs for International Doctors, 2007). Despite McKendry (1999) and Baines’ (2010) prediction of physician shortage resulting from physician retirements and unequal number of Canadian graduates required to balance the need, or Crutcher, et al’s (2011) prediction that immigration in the twentieth and twenty-first centuries resulted in a shortage of doctors, IMDs fail to succeed in filling the need.

IMDs make up one of the largest groups of international professionals who endure suffering from the devaluation of foreign credentials (Basran & Zong, 1998; Boyd and Schellenberg, 2008), de-skilling, and non-recognition of language and culture (Bauder, 2003). Working in underemployed jobs with a medical degree adds significant economic losses to IMDs’ financial and human capital. While their investment in education and developing transferrable skills as their human capital, these investments do not equate to yielding better economic outcomes (Becker, 1964) after moving to Canada. Moreover, this loss transfers to a
serious loss in the economic and patient care needs in their home countries where the shortage of doctors is also very high. It transfers to a waste of skills and talents in Canada where the doctor shortage continues to rise.

Another contradiction is the large number of IMDs who pass the MCCEE but Visa and CIMG graduates occupy more retraining spots over IMDs. Studies show that medical schools train up to 30% Visa medical graduates from the Middle East and other countries in residency programs. 47% of CIMGs are selected for retraining compared to 33% to IMDs (CAPER, 2013). Between 2009 and 2012, 7,660 IMDs passed the MCC exam over 1,830 CIMGs (Health HR, 2013, p. 19) while other reports show that between 2006 and 2010, 2,904 Canadian citizens passed the Medical Council of Canada exam, compared to 8,417 citizens of other countries (CAPER, 2011, p. 81). All in all, IMDs are passing the required Canadian exams, but fewer are selected for retraining residency positions. The Auditor General of Ontario (2010) reported that approximately 14% of Ontario patients in Ontario have no access to family doctors. Despite this shortage, medical schools seek to train Visa students for a fee rather than training already trained IMDs who can contribute to the healthcare of patients, the country’s economy. Patients end up going to expensive emergency units because they need medical attention and do not have family doctors. The emergency visits add further costs to the healthcare budgets. Moreover, it does not allow patients to receive continuity of care for sustained health by a family doctor.

On the global scene, Canada has ranked closer to the bottom of the Organization for Economic Co-operation and Development (OECD) countries with 2.5 doctors to every 1,000 population while the OECD rate is 3.2 doctors to 1,000 patients (OECD, 2014, p. 2). Busing (2007) discusses that Canada has rich information and preferred models from associations and governments to reduce the doctor-shortage need. Nonetheless, Canada continues to have substantial unmet needs. Busing (2007) calls for self-sufficiency of doctors through home-grown production of doctors in Canada, despite acknowledging the important contributions of “international” medical graduates in Canada (p. 176). In the 2009, representing the 17 Canadian Faculties of Medicine in the House of Parliament in Ottawa (as cited in Parliament of Canada, 2009), he called for a reduction of Visa trainees training in medicine in Canada by 50 positions, and transferring those positions to IMGs (comprising of both CIMGs and IMDs) (Dr. Busing section, para. 11). He showed that retraining 50 more IMGs per year will benefit the IMGs and fill the doctor shortage. He referred to this initiative as a “win-win opportunity on a small level”
(para. 11). The “win” nonetheless, seems to be a greater benefit for CIMGs as 47% of CIMGs were recruited compared to 33% IMDs (CAPER, 2013).

Whichever way one looks at this, IMDs are encouraged to immigrate to Canada from international countries. As international medical graduates, their contributions to the medical system are recognized as important but not being utilized to serve a purpose. They are accepted for immigration to Canada and come prepared to engage in top-up training before they can start to work as doctors (Dove, 2009; Busing, 2009). However, when Busing sought for an increase in retraining positions for IMGs, he focused on securing increased retraining positions for CIMGs and not for IMDS (Busing, 2009).

When an oversupply of doctors emerged in Canada in the late 1960s, resulted from the high flow of doctors immigrating from Britain and Western Europe, the government’s reaction to reduce medical schools’ enrolments and close some medical schools as a cost-saving measure, reached great resistance from Canadian physicians and leaders. The demand to train home-grown doctors in Canadian medical schools persisted (Evans, 1976). With the introduction of Canada’s welcoming and non-discriminatory 1967 immigration policy (Whitaker, 1991), a new influx of immigrant doctors from developing countries started to arrive in greater numbers compared to other professionals (Boyd & Schellenberg, 2008) who seem to fit within Guo’s description of an “immigrant” (see Guo, 2009). Over forty years later, medical doctors from developing countries continue to immigrate and continue to fall into the unfortunate category as “immigrants,” unsuitable for retraining and relicensure to practice medicine in Canada. Numerous assessment and evaluation options to select the best IMDs to fit into retraining programs have been explored but the number of IMDs being selected for retraining programs continues to decrease.

More recently, the U of T developed a best practices program to better assesses and select IMDs (BPAS, 2013) as I discuss later. Others have suggested more research is needed to better determine how to recruit and retain IMGs for the practice of medicine in the rural areas (Dove, 2009). Dove also suggests more research should be conducted to determine how to set up guidelines for coordination of provincial licenses with licensing bodies, federal immigration authorities and regional recruitment bodies on best methods on how to recruit and retain IMGs in rural areas (Dove, 2009). Robert Evans, a medical economist, points out that “the value-for-money question is becoming increasingly difficult to answer” when it comes to evaluating the
services doctors provide in the different areas of medicine (cited in Mendleson, 2010). There are no specific ways to measure these in the escalating health care cost but Emery and Ferrer’s calculation works out that it would be cheaper to accredit immigrants in Canada (cited in Mendelson, 2010), similar to Evans earlier calculation in 1976 to retrain of British/European IMDs (Evans, 1976). Nevertheless, the idea that Canadian physicians and the medical profession prefer home-grown doctors and the governments would fund whatever doctors wanted to do (cited in Mendelson, 2010), still lurks in the background while the complexity and broad governance issues seems to contribute to restricting IMDs from entering the profession (para. 11).

Canada continues to accept IMDs and their families as new immigrants. It accepts other international and precarious workers, refugees, and students each year. In 2011, 36,700 economic-class immigrants with 15,291 dependents arrived in Canada, creating a total of 51,991 newcomers to Ontario alone (Statistics Canada, 2011). Despite this mix, the focus is on training home-grown doctors to meet the growing doctor shortage. New programs by the RCPSC and CFPC, such as the CFPC (2011) *Triple-C Competency-Based Curriculum* program and the RCPSC (2014) *Competence by Design* curriculum, both of which are based on an English-based curriculum, are developed to give residents in training, a broader understanding of the needs of patients in the communities. What seems to be missing is the lack of utilizing IMDs’ foreign patientcare skills and experiences in educating and training future doctors for the diversity of patients in Canada.

**Significance of the Study**

The extent to which majority of IMDs are underutilized and forced into transforming their lifestyles from a professional to a non-professional labourer level is harsh. A smaller number of IMDs persevere to keep a grip on their career and profession. Still, the majority from this smaller group who persists continued to be denied recertification opportunities. Studies reveal that patients want and need doctors with international expertise that match their cultural background (Asanin & Wilson, 2008; Coloma, Pino, & Villanueva, 2013). Several millions of other patients are suffering from lack of appropriate healthcare and access to doctors (Leslie, 2015; Stickley, 2014; Aliaziz, 2008) while the cost to the government and taxpayers goes up because patients go to emergency hospital units to see a doctor. Despite Dove (2009) and
Busing’s (2009) beliefs that IMDs can make valuable contributions to the medical profession, there is a disconnect when it comes to capitalizing on IMDs’ skills. There is a disconnect between the need for doctors, the government’s need for immigrants, and the restrictions placed on IMDs to bar them from entering the profession. Canada and the Canadian medical profession advocate for fairness, equity and non-discrimination against immigrants and immigrant doctors, yet IMDs continued to be treated as racialized foreign bodies, unfit to enter the dominant structure. Considering IMDs credentials as foreign and expecting them to fit into the Eurocentric Canadian medical curriculum and knowledge-base for doctors seems to support the use of knowledge as power to restrict racialized IMDs from entering the profession.

Critical theorists and postmodern scholars argue that knowledge is “socially constructed, culturally mediated and historically situated to retain it as having power (cited in Guo, 2009, p. 40). Knowledge is never neutral nor objective (Foucault, 1980; Cunningham, 2000; McLaren, 2003 cited in Guo, 2009, p. 40). Guo (2009) further argues that the nature of knowledge as social relations prompts us to ask questions such as:

“What counts as legitimate knowledge? How and why does knowledge get constructed the way it does? Whose knowledge is considered valuable? Whose knowledge is silenced? Is knowledge racialized? (p. 47).”

The participants in this study are graduates from medical schools accredited by the World Health Organization (WHO, 2016). Retraining to update their medical knowledge and skills before working in the medical profession in Canada was obvious in their minds. Learning the Canadian medical system and standards before engaging in patient care was recognized by them as necessary. Expectations to make lifestyle, financial and educational adjustments in preparation to engage in the medical recertification process were necessary but complex. However, while IMDs are motivated and determined to be successful, the lack of mandatory retraining programs that leads to relicensure puts a halt on IMD plans. I seek to explore the impacts on IMDs’ lives after they become qualified, but then denied professional opportunities using qualitative research with open-ended questions as listed in the next section.
Research Questions

I drafted the initial set of research questions with input from my supervisor and conducted two mini focus groups to explore the suitability of the questions for the study. The focus groups were made up of IMDs from different countries and different specialties of medicine. They have all experienced the medical recertification process in Ontario and have not been successful in securing a medical license to practice medicine. Below are the finalize questions for this study:

1. What motivates IMDs to immigrate to Canada?

2. How does being denied medical recertification impact the lives of IMDs:
   a. Professionally, as a professionally trained doctor in a new country?
   b. Personally, as a single individual or an individual with a family and family responsibilities?
   c. Socially, as a person living in Canadian society?

3. What recommendations do IMDs make to improve the medical recertification system for IMDs in Canada?

Definitions

The following definitions relate to institutions and stakeholders that play a major role in determining the acceptance of IMDs into Canada, evaluating their eligibility for retraining, and certifying and issuing licenses.

**IMDs**

“Immigrant medical doctors” who were born in countries outside of Canada, the US, Britain, Australia, and New Zealand and have obtained their MD degree in an international medical school accredited by the World Health Organization.

**IMGs**

“International medical graduates” are doctors who studied medicine in international medical schools accredited by the World Health Organization. IMGs also include Canadians who have studied medicine in international schools referred to as CSA or CIMGs and IMDs.
**CIMGs**

Canadians who studied medicine in international medical schools are referred to as CIMGs in this study.

**Ministry of Citizenship and Immigration Canada (CIC)**

The CIC is responsible for enacting policies and guidelines to facilitate new immigrants, such as IMDs, precarious workers, refugees, and students, as per the needs of Canada. It funds centres such as the HRSDC (approximately $87 billion) to help Canadians increase their quality of life and contribute to the Canadian economy. More information can be found at these links:

- Immigration, Refugees and Citizenship Canada
- Human Resource and Skills Development of Canada

**Ontario Ministry of Health and Long-Term Care (MOHL-TC)**

The MOHL-TC is responsible for establishing a patient-focused, results-driven, integrated, and sustainable publicly funded health system in Ontario. It provides funding to universities for training doctors to meet the needs of the population and to numerous centres to assist newcomer immigrants to Ontario. It provides overall direction and leadership for the system, focusing on planning and on guiding resources to bring value to the health system. It is less involved with the actual education, training, licensing, or delivery of health care. It is more involved with establishing overall strategic directions for provincial priorities and monitoring and reporting on the performance of the health system and the health of Ontarians. Follow this link for more information about the Ministry.

**IMD Registry, exam evaluation and CaRMS centres**

Newcomer IMDs to Canada wishing to continue their medical career and practise medicine in Canada must register at the physiciansapply.ca site first. This registry allows candidates access to all Medical Council of Canada (MCC) examinations and write the various qualifying exams such as LMCCEE Part 1, CE1 and CE2 as necessary, NAC OSCE, and others. IMDs send all their medical credentials for source verification, share documents with registered stakeholders, and apply for medical registration. This site is in collaboration with HRSDC.

Once IMDs pass all the exams, they then apply to CaRMS for consideration for a retraining position, which ultimately leads to licensure. Details are provided at the following websites:

- physicianapply.ca
- Medical Council of Canada Exam and Evaluation
- CaRMS.

**Supporting MOHL-TC Centres for International**

The MOHL-TC funds many centres such as HealthForce Ontario, CEHPEA/Touc...
Health Professionals

They do not provide advice, financial assistance, professional development/university upgrade courses, or best practices to prepare IMDs for a residency training position. They do not provide feedback on the application or proceeding with competition for a retraining position. There is one centre specifically designed for Career Transitioning of IMDs outside of the medical licensing options pathway.

Certification Exams: CFPC

The Canadian Family Physicians of Canada (CFPC) is the national organization responsible for setting the goals and objectives for family medicine training and family doctors, which takes place in medical schools and hospital institutions. Every IMD wishing to practice medicine must first be granted acceptance into a residency program and retrain under the CFPC 2-year residency program. Successful completion of the CFPC training curriculum, supervised by a family physician faculty member, and then recommended by the Program Director as satisfactorily completed leads to the trainee’s eligibility to write the national CFPC exam. If successful at this exam, the trainee then applies to the licensing college (i.e., the CPSO) for a license to practice medicine. The CFPC accredits all family medicine residency programs in all medical schools in Canada.

RCPSC

The Royal College of Physicians and Surgeons of Canada (RCPSC) holds national responsibility, similar to the CFPC, but for all other 5-year specialties in medicine in Canada. Trainees, including IMDs, go through the RCPSC process similar to the steps in the CFPC process for a license to practice medicine in their field of study. Licensure and accreditation processes are also similar to the CFPC. More details are at: CFPC | RCPSC.

Postgraduate Training

Postgraduate training programs in medical schools in Canada must meet the accreditation standards of the CFPC and RCPSC, deliver the appropriate residency curriculum, and ensure trainees are educated and trained satisfactorily to be successful in the national exams, which lead to licensure. Medical residents are persons with a medical degree accepted for residency training in a medical school in Canada.

Licensing Colleges

The licensing colleges issue medical licenses to study in a residency program and to practice medicine after successfully passing the national exams. Each province in Canada has its own licensing college with its own rules and guidelines; e.g., the CPSO in Ontario. Licenses are only issued on successful completion of the education and training requirements needed for the specialty and on successful passing of the national exam.
Organization of the Thesis

This thesis is organized into ten chapters. The first chapter provides an introduction that contextualizes the background, research questions, and significance of the study. Chapter 2 provides a historical overview of the emergence, formation, and influences of the medical profession in Canada that give it the British/English shape and control it has today. In Chapter 3, the literature review discusses existing research on IMDs, human capital, the medical profession, and the loss IMDs experience as new immigrants to Canada. Chapter 4 elaborates on the anti-colonial theoretical framework of the study and other supporting theories and conceptual framework for the study. Chapter 5 describes the design, methodology, analysis of the qualitative data collected for the study and limitations to the study. Chapters 6, 7, and 8 describe the findings of the study. Chapter 6 examines how IMDs are motivated to immigrate to Canada. I apply Maslow’s (1954) theory of motivation to support IMDs’ self-actualized goal to practice medicine in Canada. Chapter 7 looks at the economic quandary of IMDs and the costly financial waste of human capital both to the IMDs themselves and to the government, from not capitalizing on IMDs’ skills and talents. Chapter 8 focuses on the impacts of the denial of medical recertification opportunities on the lives of IMDs from a professional, personal, and social perspective while Chapter 9 presents an action plan for change. Finally, Chapter 10 presents recommendations for addressing the questions in this study, followed by a conclusion to the thesis.

Conclusion

People have said to me that if the literature suggests IMDs as having language, culture, education and credentialing deficiencies, unsuitable for the Canadian medical profession, why bother wasting time researching or retraining them? They say that IMDs will continue to have the same problems as most immigrants trained under different medical and education systems. Although I am aware of the perceived deficiencies of IMDs, and immigrants in general, face in entering the workforce equal to their qualifications, I believe IMDs possess valuable international knowledge and experiences that may be beneficial to the Canadian society and medicine. These skills should not be brushed off as foreign and unfit for Canadian medicine, especially when the Canadian patient population is growing in culture and ethnic diversity and the need for doctors are on the rise. They should not be left untapped but explored.
The profession bears the marks of professional control and dominance to maintain regulations and sustain traditional norms. While doing so effectively, IMDs suffer. Patients suffer. Healthcare costs rise and concerns of discrimination, inequality and injustices against IMDs as immigrants and foreigners persist. If Canada accepts highly educated immigrant doctors and promises transitional career opportunities while claiming to be democratic and non-discriminatory, more actions are needed to fulfil these commitments and curb the waste of skills and human capital. It is my hope that the recommendations proposed in this study, echoing the voices of IMDs and others in the literature, will stimulate discussions and interests to vigorously explore this topic in greater depths and lead towards solving the long-standing problem IMDs face in Canada.
Chapter 2
The Medical Profession in Canada: A Historical and Contemporary Context

A historical approach is integral to the make-up and understanding of Western medicine (Warner, 2011). Since the establishment of medicine in Canada, under the British colonial influences and ideologies over two hundred years ago, the theory, practice and delivery of patient care have changed significantly. This chapter sets the context for understanding the history of medicine in Canada and how this history has contributed to perceptions of IMDs as “foreign” to the profession. I begin with an explanation of British and colonial influences in medicine, including the medical acts and regulatory, licensing and examination bodies that control the profession, and follow with an overview of the Canadian healthcare system. Further, I look at the development of the medical associations, medical schools, and other stakeholders of the profession to understand the relationship within the profession and IMDs seeking to continue a medical career in Canada. I conclude by probing the different pathways to medical certification for Canadian-trained graduates and foreign-trained IMDs while questioning the reality of Canada’s commitment to transitioning IMDs into professional work in Canada.

British Influences in Medicine

Historically, the theory and practice of medicine in Canada experienced ongoing changes since the arrival of the European and British explorers in the sixteenth century (Historica Canada, n.d.). Prior to the arrival of the explorers, medicine was practiced in Aboriginal Native communities by traditional medicine men. After the arrival, semi or un-trained physicians emerged to care for the people (p. 1). As a result of New France ceding to the British in 1763 and Canada became a British possession through the conquest of General Wolfe in 1759 (Canniff (1894, p. 2), the British took control of the practice and organization of medicine (p. 1).

Historical accounts also document that the British depended on the Native Canadians and settlers for their strength in fighting and hunting, and therefore endeavored to provide them with medical care and restored health to keep the population healthy. The British leaders brought English doctors from England. Doctors from the British navy and army who retired from service also came and settled in Canada (Taylor, 1960). These doctors proceeded to open private medical practices in the large cities (Canniff, 1894). They earned income for their services, thus the emergence of medical dominance in pre-industrial medicine (Torrance, 1998) and fee for
medical services. Loyalist doctors who fled the 1776 American Revolution to Canada were deemed unsuitable to fit into the English style medicine practiced in Canada. Their medical education and training and kinds of medicine they practiced were different from the expectations in Canada. They faced similar challenges as IMDs today, in gaining medical recertification to practice medicine in the developing Canadian societies (Historica Canada, n.d, p. 1). Even though the need for doctors rose due to the influx of migrant Loyalists and patients could not afford the high fees of the English Elite doctors, Loyalist doctors who were ready and willing to care for the patients at cheaper rates, were deemed ineligible for relicensure (Blishen, 1969). As Loyalist doctors persisted in seeking relicensure, the leaders of the medical profession at the same time continued to push back with the aim to ensure the standards and regulations of the profession are maintained.

As early as 1778, the government introduced the first Medical Act to restrict who can be licensed to practice medicine and how many foreign doctors can enter the profession while maintaining the standardization and regulations of the profession as a colony of Britain (Blishen, 1969; Canniff, 1894; Deacon, 2005). The 1788 Act further ensured the British elitist nature of medicine and the social development in the history of Canadian medical licensing laws (Torrance, 1998). A few years later, in 1795, a repeated attempt was made to pass legislations to license only English-trained doctors and bar the entrance of foreign doctors who practiced medicine foreign to the standards of English style medicine, as well as other non-allopathic healers from entering the profession (Torrance, 1998). Anyone who claimed to be a doctor and did not reach the English standards for medicine, was not given consideration for a license to practice medicine (Torrance, 1998).

Fast forward to the 1830s, smallpox invaded the land. It led to a huge epidemic that spread in the Hudson’s Bay fur trading company. Up to three quarters of the Native Indian population, who were assets to the fur trading business as experts of the trade business, were destroyed (Torrance, 1998). Maintaining the good health of the remaining Native population was crucial to the British leaders for economic reasons. As such, they forged together to oversee medical care to the Natives and the general population. According to Torrance (1998), this overseeing introduced even greater professional autonomy and control of the profession. The leaders gave themselves authority to appoint physicians, determine hospital admitting privileges, prescribe drugs with exclusivity, and more. Scientific pharmaceutical drugs were not in existence
yet. Rather, herbal remedies based on roots, barks, leaves, seeds, and other items found in the woods were used as medicine until later discoveries and education with physicians such as Sir William Osler (1849-1919). Developing and understanding the anatomy of the body and diseases, pharmacology, public health and immunization, as well as medical education and regulations excelled (Historica Canada, n.d.a). Osler himself came from a lineage of medical officers and lieutenants in the navy and army. His father, grandfather, and uncles were in the Royal Navy. Living in Ontario, he attended Ontario universities where he completed his medical education, followed with postgraduate training in Europe. He played leading roles in the administration and development of medical education in Canada. He also held several positions in US universities before accepting an appointment as Regius Chair of Medicine at Oxford University, England, in the later years of his career and leaving behind a textbook on the principles and practice of medicine and guidelines for public speaking and confidence building in the medical profession.

**Tenacity of Medical Doctors**

Osler was a clear public speaker and a prolific author and writer. His book, *The Principles and Practice of Medicine*, became the key textbook in medicine. Over one hundred years later, his textbook is still in use as a primary textbook in medical education in Canada. Osler was also highly respected as a prolific leader in the field of medicine. His academic, scholarly and public speaking skills, and confidence, made him a role model for doctors. His knowledge and style of writing and speaking became the influential norms in medicine (Historica Canada, n.d.a). These are some of the competencies and skills passed down to generations of Canadian trained doctors and made up the culture and expectations of the profession.

Taylor (1960), Blishen (1969) and Naylor (1986) also discuss the tenacity and commitment in men, and particularly Englishmen, who chose to study medicine. These men would spend many long years immersing themselves in the profession while committing and following the founding leaders of medicine. They dedicated as many as 14 or more years to the study of medicine and to becoming indoctrinated in it. This commitment and dedication helped pave their way to joining the rank of exclusive elite doctors. The exclusivity gave doctors a prestigious position in society, more so because this was a time when education was limited to
the upper class. Doctors were seen as the privileged learned elite men of medicine (Blishen, 1969; Canniff, 1894). Those who migrated to Canada set up medical practices in large cities. They billed patients for their services and this billing became their personal income (Blishen, 1969). They also received income protection and support from the administration and the colonial government (Canniff, 1894; Deacon, 2005) as a means to maintain their professional status. As Albert Memmi’s (1965) critique of colonialism, he argues that British expatriates move to colonies where the basic economic advantages “were preserved” (p. 6). They move with the thinking of the colonizer’s mindset to profit from others in the colony. Whether this was the case of the British doctors or not, the colonial influences to develop medicine, to preserve economic advantages and profit from the colony through leadership in medicine seems to prevail.

By the 1800s, Canada saw the rise of new medical institutions and schools with an English curriculum taught by English influenced professors and physicians (Taylor, 1960). As the status of medical surgeons rose to higher prestigious levels than general practitioners in England, partly because surgeons had military associations with the colonial elites of England, the elite status of surgeons in England also made its way to surgeons in Canada (Blishen, 1969). Leading English medical doctors and educators sought to guide the profession into the British-English style they were familiar with (Blishen, 1969). Today, it continues to be recognized as one of the leading specialties of medicine in Canada.

The British influenced teaching and practices of medicine also guided the licensing and eligibility criteria for the practice of medicine in Canada (Blishen, 1969). While the demographics of the Canadian population started to shift over the decades, the teaching, practice, and culture of medicine, influenced by the founders of medicine and later by textbooks such as Osler’s textbook, continue to shape medicine under the homogeneous Eurocentric English colonial model of medicine. Immigrant doctors from British colonies such as Australia and New Zealand, trained under the British model, encountered less difficulty accessing the profession. However, doctors from non-White British colonies such as India, Pakistan, and countries in the Middle East or the West Indies, despite their English-influenced medical education and meeting the Canadian requirements for retraining programs, experienced greater difficulties gaining access to the profession, despite their tenacity for medicine.
Fair Selection

As depicted in Figure 1, fair selection suggests “everybody has to take the same exam.” Anyone wishing to practice medicine in Canada is therefore required to "climb the same tree," have the same knowledge base, and follow the same pathway as requested by the examiner behind the desk. This request appears to be tolerant and fair to all IMDs from all backgrounds.

![Cartoon of a tree with a sign that reads: "FOR A FAIR SELECTION EVERYBODY HAS TO TAKE THE SAME EXAM? PLEASE CLIMB THAT TREE"](image)

Figure 1. Fair selection.
Source: Henry Kotula, Cartoon – Fair Selection Process

This portrayal of fairness in the profession gives IMDs the impression that if they meet the qualifications required, they can climb the same tree as any other doctor. After all, they are already trained doctors. They can learn the new requirements needed to satisfy the examiner. They are just as competent as others in their group, irrespective of color, size, or looks. With Canada’s Employment Equity Act (1995) designed to achieve equality in the workplace for all persons, without discrimination on the grounds of race, origin, color, or ethnicity (see S.C. 1995, c. 44, 1), it should be a fair selection for IMDs. However, this has not been the case in the history of the profession according to the literature. Applying a one-size-fits-all criterion to measure immigrants’ credentials and experiences, denies immigrants the opportunities to be successful in a new society (Guo, 2009), which is what we are seeing. These kinds of professional standards and excellence act as a “cloak to restrict competition and legitimize existing power relations” (p. 49). This kind of juxtaposition of misperceptions can be subtle, but forms a “powerful head tax to exclude the undesirable and perpetuate oppression in Canada” (p. 49).
Medical Acts in Evolution

As mentioned earlier, the Colonial government and medical leaders in Canada started to introduce medical acts from as early as 1788, shortly after Loyalists doctors started to flee America to Canada during the 1776 American Revolution (Blishen, 1969). The first ever Medical Act was introduced with the purpose to restrict medical licenses only to Loyalists doctors who met the requirements comparable to an English trained doctor. The need for doctors increased as Loyalists flee to Canada. Many Loyalists did not have the economic means to pay the costly fees to see an English doctor for essential care such as child birth, surgery and other serious illnesses. Loyalist doctors who could care for the Loyalist patients, and sympathetically wanted to care for them, were refused licensing because of their foreign education and experience, not equivalent to the English doctor (Blishen, 1969). Others who practised herbal medicine or other non-allopathic medicine, considered irregular medicine by the profession, were seen as quasi doctors and inadequate to enter the regulated medical profession (Blishen, 1991). In the 1800s, the era that brought in increased immigrants and pioneers from England and the US to settle the land (Whitaker, 1991), the need for affordable doctors increased as well. However, the focus remained on licensing doctors who are equally qualified as English trained doctors (Blishen, 1991) and new medical acts were introduced to enforce regulations in the profession.

For example, new Acts were passed in 1818, 1819 and 1827 with the primary purpose to further restrict foreign and non-English trained doctors and others deemed to be practising any kind of irregular or quasi-homeopathic style of medicine (Blishen, 1991). In 1839, ppolitical pressures from practising doctors steered the profession into introducing another act to establish a Medical Board with the authority to determine who can practice medicine and gain access to the profession (Canniff, 1894). The London Licensing authorities in England, however, felt that this level of authority to the Board would infringe too deeply on their rights to control the profession, thus another Act was introduced in 1839 to retain control. Fast forward, about 25 years later, a revised Medical Act was introduced in 1865 in Ontario (then known as Upper Canada). This Act led to the establishment of the General Council of Medical Education and Registration under the College of Physicians and Surgeons of Ontario (CPSO). It gave the Council the responsibility to examine medical students and license them to practise medicine in Ontario (CPSO, 150 Years, n.d.). In 1869, another Act was passed in response to the public’s
strong demand for services from heterodox practitioners in rural areas of Ontario (Blishen, 2016). Today, the CPSO continues to have the power to control educational standards of medicine for the province, including the rural areas. It continues to be responsible for issuing of licenses to qualified doctors in Ontario (CPSO, 150 Years, n.d.). Several other Acts were passed with the most recent one being the 1994 Regulated Health Professions Act (RHPA) that relates to patient sexual abuse. Nonetheless, the 1865 Act responsible for examining medical students and licensing them to practise medicine in Ontario remains crucial in Ontario.

Some argue that the historical actions of the medical profession and the government have little importance to the profession today; that things have changed and medicine has become more independent of the past. This closer examination shows that these initial Acts to establish the profession and bar those deemed unsuitable, formed the backbones of the profession. They have set the precedents as influenced by the colonial government and the founders and leaders of the profession. These precedents continue to hold firm grounds in controlling the profession today and also responsible for ensuring high standards and ethics in medicine with collaboration of the various stakeholders.

The Stakeholders

The Canadian medical profession is comprised of a complex body of organizations, all of which play an integral role in how the profession operates, how it fits in the structure of Canadian society, and how it regulates. For the purposes of this study, I focus only on the primary stakeholders in this section.

Medical Council of Canada

The MCC (2016) is chiefly responsible for the examination process and all evaluation and testing of physicians seeking to practice in Canada. It was founded in the late 1800s after almost 18 years of campaigning for a suitable national qualifying exam to ensure the competency of doctors (para. 3). The MCC Evaluating Exam (MCCEE) now comprises two parts (MCC, 2015). Anyone who receives an MD degree in any country and wishes to practice medicine in Canada must first pass Part I of the MCCEE (Part 1) before receiving further training. Canadian residents write the same exam. Residents in training write the MCCEE (Part 2) of the exam to become eligible for the Licentiate of the Medical Council of Canada. The goal of these exams is to maintain uniformity and a high standard by which to assess physicians’ competencies. The
exams are continually modified by the MCC to ensure the effectiveness of doctors’ competencies and expertise. IMDs are required to write the MCCEE (Part 1) if they wish to proceed with seeking medical recertification.

**College of Physicians and Surgeons**

Each province and territory in Canada operates its own licensing college. Ontario, for example, has the College of Physicians and Surgeons of Ontario (CPSO). These colleges are responsible for establishing the criteria that qualify a physician or a surgeon to practice medicine in the province. They are responsible for issuing licenses to qualified doctors who meet the requirement and under the guidelines and parameters set by the overall regulatory bodies of the profession. For example, the CPSO by itself cannot promise education, licensing, increase of IMD positions, or issuing of licenses to IMDs who have not completed the necessary postgraduate retraining or alternatives and pass the CFPC or RCPSC accreditation exam. Provincial Colleges may tend to believe and want to support needs for doctors as arisen in their province, however, they are still restricted from issuing a medical license to an IMD or others who have not gone through the necessary medical recertification and retraining processes. As they have the best interests and needs of their communities in the province, they may make attempts to support specific needs (Taylor, 1960) such as the CPSO did for women almost one hundred and fifty years ago when it finally broke away from traditions and offered a license to the first woman in medicine (CPSO, 150 Years, n.d.).

At the beginning of the development of medicine in Ontario women were banned from entering medical school or studying medicine. Medicine was a totally male-dominated profession (Davenport, McDonald, & Moss-Gibbons, 2001). Through continuous suffrages and determination, Emily Stowe became the first woman to apply and refused medical school education in Canada. Instead, she went to the US where she gained her medical education (Baros-Johnson, 2004; Library and Archives Canada, 2010, para. 2). For thirteen years, she practiced medicine in Ontario illegally (without a license) because she refused to do the Canadian exams. Eventually, she was offered a license and became the first woman physician to break the barriers for a medical license in Ontario (para. 2). Her daughter, Augusta Stowe-Gullen, followed her mother’s suffragist pathways. In 1879, she became the first woman to be
accepted by the U of T medical school. Graduating in 1883, she became the first woman in Ontario to be educated and licensed to practice medicine in Ontario (para. 3).

What does the suffrage movement had to do with IMDs one may ask? Firstly, the CPSO was the first Licensing College in Canada to go against the odds of the profession and eventually recognize, accept and license women into an all-male dominated profession (Blishen, 1969). When I joined the U of T medical school as an administrative staff in 1981, I had the privilege of seeing the excitement and preparation for the 100-year anniversary of the first woman at the U of T medical school. It was an exciting time for the school and the administration as they recognize their leading role in accepting women in medicine in Canada. Today, women have reached equal access to medicine in medical schools and in being licensed to practice medicine.

Medical Regulatory Bodies

There are two regulatory bodies that guide the Canadian medical profession: The RCPSC founded in 1929 and the CFPC founded in 1969 (Taylor, 1960). These two colleges are responsible for ensuring that medicine and medical training in Canada are conducted under strictly accredited guidelines. They focus on providing the best physicians to care for patients while upholding the profession’s status, prestige and professionalism, and stopping any erosion of the profession in the healthcare system (Taylor, 1960; Blishen, 1969).

In 2005, the RCPSC (n.d.a) rolled out a comprehensive CanMEDS Framework (see Figure 2), designed to enhance physicians’ medical competencies to further improve patient care and standardize physicians’ training across Canada. The framework identifies that a medical doctor in Canada must be an expert in his/her specialty. To do so, physicians must excel in the six different roles determined as efficient to prepare doctors to be medical experts as listed in Figure 2, namely: be a good communicator, collaborator, leader, health advocate, scholar, and professional (Frank, 2005, p. 26). The CanMEDS provides a comprehensive foundation for medical education and the practice of medicine in Canada. Since the release of the initial pilot-project in the mid-1990s, CanMEDS has continued to receive attention nationally and internationally. Modifications are always being made to keep it current and effective (RCPSC, n.d.a).
Rather, the CanMEDS framework (RCPSC, n.d.a) is based on empirical research, sound education principles, and extensive stakeholder consultation. It has been adopted internationally by other programs. It has become the dominant blueprint of competencies for the teaching and practice of medicine in Canada and supplements the long-established four principles of the CFPC for family medicine practitioners (Figure 3), namely:

1. Being a community-based physician
2. Establishing a patient-physician relationship
3. Being a skilled physician, and
4. Being a resource to a defined population (CFPC, 2009).
In addition to the RCPSC and CFPC ensuring that physicians are competent at graduation to practice their specialties, continuing medical education and professional development are also vital (Crutcher, et al, 2011). IMDs selected for retraining are expected to fit within this category of the CanMEDS if they wish to practice medicine in Canada. The questions I pose here are:

1. If IMDs are new to Canada, how can they meet the collaborator, manager, health advocacy and scholarly competencies of CanMEDS if they have never studied, trained or worked in the profession?

2. Is this a fair process for evaluating IMDs?

3. Should there be a different model to assess IMDs’ competencies for retraining for a license to practice in Canada?

**Governance and Administrative Structure of the Medical Profession**

Leading stakeholders of the medical profession have individual unique governance structure with appointed individuals who act as the decision-makers of the institution. The
RCPSC has a governing Council consisting of a President, a Past-president, and various representatives from across the regions of Canada (RCPSC, n.d.a.). The RCPSC Council acts as the College’s policy-setting board and has authority as the “ultimate” decision-making body for the College (p. 1). After reviewing the 16 members of the Council, it seems that only two members may qualify within the international medical graduate category of physicians, based on the names: namely, Dr. Rungta and Dr. Nakajima (RCPSC, n.d.a., para. 1-2). What I find interesting here is the homogeneity of the Council and the lack of diversity in this membership. I have no doubt that members of the Council are very talented and have the best interests of education and patient care at heart, but as Canada’s patient population is growing in diversity, and patients are calling for the need to see doctors who can understand them (Asanin & Wilson, 2008; Coloma et al., 2013; Esmail, 2016), would it not be more helpful to have IMD representatives on this Council who knows IMDs and patients’ diversity and needs, to provide these voices at the governing table that plans for delivery of patient care to the wider diverse patient population? Would it not be more helpful to have the perspectives of visible minority physicians’ voices in the leadership, and ultimately in the planning and decision-making groups, that determine the needs and patient care for the growing body of ethnic minority newcomers and refugees arriving in Canada each year?

There are also four appointed members representing the public on the Council. Again, there is no evidence of minority or ethnic representation among this group. Could one of the four voices be a voice for visible minority IMDs on behalf of IMDs and ethnic patients’ care? Currently, the membership is comprised primarily of individuals with LLM, LLD, PhD, and JD degrees, who are not at a similar level with IMDs or patients. They likely do not have the experience of seeing an IMD in an unfamiliar foreign professional space, different by ethnicity or race and living with uncertainties of their future career. They may not have sat in a community medical clinic waiting room full of immigrant patients, where patients sit and wait for hours to see a doctor of their cultural background as I have observed in my local community. The resident member and the fellow-at-large on Council also do not seem to be of racial ethnic minority backgrounds (RCPSC, n.d.). They may not have the experience of an IMD or an ethnic patient to guide their thinking of best resolutions for IMDs. It may be argued that the members on these councils are qualified and effective leaders and champions for medicine for all the people. However, the imagery of lack of representation of visible minority IMDs or lay people
on these major governing and decision-making bodies and lack of understanding of the practicality of ethnic patients’ needs and IMDs’ contributing skills, reflects a deficiency in the governance of the profession. Similarly, the governance structure of the CFPC aims to provide accountable, timely and effective governance. It claims to seek to enhance opportunities for all stakeholders to engage with the Governing Board but again, the RCPSC and the CFPC governing boards lack representation of visible minority IMDs according to the membership composition (RCPSC, n.d.a., para. 1-2; CFPC, 2016). From a review of the names and pictures of the membership of the CFPC senior advisory team, member representation of doctors of visible minority backgrounds seems to be lacking as well.

At the university academic level, each of the 17 universities in Canada, has an established medical school. Each medical school listed below, has a Dean responsible for the leadership and postgraduate medical education and training of the school (Association of Faculties of Medicine of Canada, n.d.b.):

<table>
<thead>
<tr>
<th>Dalhousie University</th>
<th>Queen’s University</th>
<th>University of Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laval University</td>
<td>Universite de Montreal</td>
<td>University of Ottawa</td>
</tr>
<tr>
<td>Laurentian/Lakehead</td>
<td>Universite de Sherbrook</td>
<td>University of Saskatchewan</td>
</tr>
<tr>
<td>McGill University</td>
<td>University of Alberta</td>
<td>University of Toronto</td>
</tr>
<tr>
<td>McMaster University</td>
<td>University of British Columbia</td>
<td>Western University</td>
</tr>
<tr>
<td>Memorial University</td>
<td>University of Calgary</td>
<td></td>
</tr>
</tbody>
</table>

As well, judging from the names and pictures of Deans of schools, a lack of visible minority representation of Deans is also missing in the leadership at the Deans’ level. There may be one or two members of ethnic backgrounds on other supporting committees, but no IMD, ethnic patient, or lay person representation seem to be present in the listing (Association of Faculties of Medicine of Canada, n.d.a).

Another leading influence in the medical profession is Canadian Resident Matching Services (CaRMS). This is the primary national association for matching residents to postgraduate residency programs across Canada. Again, looking at the membership of the governing body, there may be one or two student representatives of visible minority or Native Canadian Indian status on the CaRMS Board (CaRMS, 2016), but students are short-term members and may not have the same voice as Deans, Directors, or appointed physicians. As such their input is short-term. Further, I note that there is a lack of diversity representation of IMDs or
etnic minority physicians at the U of T medical school and its postgraduate medical education office. The school has a Chief Diversity Officer who is of ethnic minority background, but there is still a disconnect between representation of IMDs in the administration and selection and retraining of IMDs in the medical school. I am aware that foreign names or colour of skin are not indicators of diversity or ethnicity. However, the domination of “white” traditional Canadian voices governing the recruitment, training, and distribution of doctors for a community of patients that is almost 50% non-white and non-English Canadian, I feel, warrants the voices of visible minority for fairer representation at these leadership and decision-making levels of the profession.

Governance in organizations or institutions is the process of decision-making. It is the process by which decisions are made and implemented by formal and informal actors and structures while ensuring accountability, transparency, equity, inclusiveness, views and voices of minorities, but also voices of the most vulnerable in society so their voices can be heard (United Nations-ESCAP, n.d.a., Good Governance section, para. 1). The U of T’s stand on good governance is public accountability, transparency, excellence in teaching and research, stewardship, and diversity of representation of governors (Governing Council, 2015). A study by Jones, Shanahan, and Goyan (2004) on university senate, within the context of university governance in Canada, shows majority of respondents agreed that the role of senate is to represent the best interests of constituencies of the broader society and the university as a whole (p. 57). More students than administration agreed that their role on senate is to represent specific constituency. They agree that the strongest support on the governing body should be to represent the best interests of the university (p. 57). This, however, does not mean that visible minorities will not be supportive of the university’s interests. Further, 62% of participants agreed that a senate should be involved in a role in lobbying for change in government policy (p. 57).

The U of T was also under a historical two-tier bicameral model of governance. One tier represents a corporate board of government appointed citizens to be responsible for administration of the university. The other tier responsible for academic matters (Jones et al., 2004). Both tiers worked independently with limited representation of constituency membership and transparency and open-ness in governance. They kept their issues from each other very secretive but the U of T became one of few universities that moved away from a historical two-tier bicameral system and accepted the Duff-Berdahl unique model for a unicameral governance.
The unicameral model allows for one decision-making body, inclusive of all its constituencies of faculty, staff, students and others (Jones et al., 2004). See University of Toronto Governing Council (2015).

Stakeholders associated with the medical profession are committed to good governance and to meeting the social needs of society. While the U of T’s governing body portrays a good representation of all constituent body, this kind of representation is missing in the governing bodies of the stakeholders of the profession. Representation of inclusiveness, participating views, and voices of minorities (United Nations-ESCAP, n.d.a) to represent all people of the province (almost 50% ethnically diverse), is missing in the governing and decision-making bodies of the profession. The absence of IMDs at the governance level within stakeholders should be a mark for concern of equity and inclusiveness of key constituent groups in the governing body. It should be a mark of unfair representation in view of decision-making. This lack should be pursued to bring equity, inclusion, fairness and social justice with minority representation in the governance of the medical profession via the stakeholders.

Medical Schools: Professionalization of Medicine and Academia

Medical schools started to emerge in Canada in the late 1700s with the purpose of educating people through a formalized education program (MacPhail, 1968). The first medical school opened in Canada was in Quebec at the McGill University in 1824. Other schools started to emerge, including the U of T medical school which opened in 1843. By the early 1900s, most provinces in Canada had at least one medical school. Establishing these medical schools and adapting the English curriculum content and length for Canadians, as Torrance (1998) argued, became one of the key steps in the professionalization of medicine in Canada. Affiliating medical schools with universities and limiting entrance to students from higher social classes added to the transferred British/English colonial expectations of belonging to the profession. Like-minded students of a similar social class who sought the same goals and desires for medicine enhanced the respectability of the profession. Even when there were concerns about the quality of medical education in Canada and the US in the 1900s, the Flexner Report (Flexner, 1910) showed that Canada, still heavily influenced by British colonial education unlike the US, came out ahead of the US as having a more orderly curriculum and medical students (Torrance, 1998).
Over the years, medical education became more formalized. Other branches to support medicine such as journalism and research started to emerge. Research and publications grew quickly and soon became central to medical practice and education (MacPhail, 1948). By this time, several medical journals and publications were already in print, and smaller journals had already joined forces to become Canada’s leading Canadian Medical Association Journal (MacPhail, 1968). This promoted medical education and research at a higher scale and signalled a broader professionalization and formalization of medicine and medical education in Canada in the early 20th century. It signalled growth, strength, and academic prestige as medical schools linked with universities (McPhail, 1968).

No central authority controlled Canadian medical schools during this period. Rather, peer groups in medical schools used different medical associations to regulate education in the profession until 1929 when the RCPSC was established as the primary regulatory body for medicine in Canada (Blishen, 1969; Taylor, 1960). The responsibility of the RCPSC was to regulate the profession, medical training and internship programs across Canada. It has jurisdiction over all specialties and sub-specialties of medicine, medical education and residency programs in Canada (Blishen, 1969; Naylor, 1986). The CFPC, later established in 1969, has the responsibility to regulate the family medicine program across Canada (Blishen, 1969). These two regulatory bodies (RCPSC and CFPC) have the responsibility for setting the objectives for specialty training programs, accrediting medical schools’ training programs, and monitoring the final exit exams of all residents and physicians (Canadian and International), leading towards a license to practice medicine in Canada (Blishen, 1969) while maintaining the professionalization and academic rigor in the profession.

**Hospitals and Government Funding for Medical Training**

Hospitals also play a very important role in the medical education and training of doctors in Canada. Hospitals and infirmaries were originally set up in Quebec, the Maritimes, and Halifax in the early 1600s. They later spread across the country to help care for the new settlers (colonists) and wounded soldiers (Historica Canada, n.d.a). Physicians, nurses and sisters dedicated their lives to helping patients and developing medical education to improve the practice of medicine. When there were concerns about whether medical schools in the US were meeting admission, training, and graduation standards and adhering to the protocols of
mainstream science and education in medicine (Vevier, 1987), the Carnegie Foundation for the Advancement of Teaching in the US commissioned Abraham Flexner to review all US and Canadian medical schools. Flexner’s (1910) report released many recommendations for improving medical education in Canada, including the introduction of hospitals in the teaching and training of doctors (Vevier, 1987). Flexner (1910) advocated for facilities with well-equipped laboratories for hands-on clinical practice with real patients in hospital settings for teaching and training medical students. The governments and medical schools accepted Flexner’s recommendation. From that point forward, hospitals in Canada became an integral part of the education and training of doctors. Affiliation agreements and joint hospital university/academic appointments for training, education and research. Collaboration with the licensing college became mandatory in the medical profession (Vevier, 1987).

The post-World War II economy and a need for immigration to support post-war economic boom led to increased population growth in Canada (Whitaker, 1991, p. 18). It also led to the introduction of the 1967-point system immigration policy to attract immigrants from all countries (Whitaker, 1991) and played a role in the further development of scientific medicine. Rapid expansion of hospitals and federal-provincial fiscal arrangements resulting from the Hall’s Commission (1964) started to occur. Federal transfer of funds to provinces to cover health care costs became crucial to healthcare development. A Financing Act and programs were established to monitor payment for health care and a 50/50 split in funding between the federal and provincial governments to support hospitals, universities, and medical education (Hall, 1964), thus the Federal/Provincial funding split to national healthcare.

Hospitals such as the Toronto General which had the capacity to provide full academic and teaching support to medical students and residents fell under the “fully” affiliated teaching hospital category. These fully-affiliated hospitals received full operational and training funding from the governments. Smaller community hospitals such as North York General for example, with fewer resources and less training capacity, fell under the category of “partially” affiliated hospitals and also received some funding from the governments for operation, education and training. Other community hospitals not involved in teaching or training residents did not receive government funding. These were categorized as non-teaching hospitals. Taken from Flexner’s (1910) recommendations, hospitals became a vital part of hands-on medical education and
training of doctors and Federal and Provincial government funding started to flow to support medical education and training of residents in hospitals.

**Government Funded Healthcare: Evolution**

Government-funded health care was a huge undertaking by the government in the twentieth century Canada as well. Prior to 1947, medical services to patients were based on the “fee-for-service” model developed by the first English/British doctors who started to move to Canada since the 1600s. Patients who could afford the fees received medical care and treatment. Others who could not afford the fees would end up at infirmaries, dispensaries, or they relied on local remedies and naturopaths but a Saskatchewan politician, Tommy Douglas, saw this an unfair and unequal access to healthcare. Having almost lost a leg because his parents could not afford the doctor’s costs to fix it, he vowed to make changes in the healthcare system when he grew up and became the first premier of Canada to offer accessible government-funded healthcare to the people of Saskatchewan in 1947 (Blishen, 1969; Brown & Taylor, 2012). He advocated the same for all peoples of Canada. By 1949, British Columbia had followed Saskatchewan’s model. Alberta and other provinces followed suit with Quebec being the last province to join in 1961.

Healthcare was a critical need during this period. Canada had just survived the 1930s depression and the Second World War. In 1945, only 6% of the people had access to healthcare. This number increased to 53% in 1961 (Naylor, 1986). But while it was good for the people, it was a threat to the physicians and leaders of the profession as it meant taking away their freedom for fee-for-service income. They were concerned that the government would take control of the profession, see them as unable to follow their own judgment about what was best for their patients, interfere in their professional organization, and try to make them civil servants (Blishen, 1969). Physicians were concerned about losing their independent status. They saw the government control of the profession as turning it into socialist medicine. They were concerned about losing their income and prestige as medical doctors. Debates ensued to stop the plan for universal health care. Pushbacks by physicians continued well into the 1960s. Some physicians continued to charge fees they felt were reasonable for the services provided. They saw the fees as helping to cover the costs of their years of medical education and training (Blishen, 1969; Naylor, 1986) or economic outcomes from investments in education (Becker, 1964). Others
continued to charge fees independently and privately, with over three times the national average and at much higher rates for some other services because there were no standard rates for services (Blishen, 1969; Naylor, 1986). With almost 90% of the doctors on a 23-day strike to stop the government’s proposal (Blishen, 1969), patients were left with no care. As the situation worsened, the government intervened and brought doctors from Britain, the US, and other parts of Canada to provide needed emergency care to patients (Blishen, 1969).

Public opinion swung against the lobbying doctors. Empathy for doctors’ support had started to wane. The CPSO called off the strike with agreement of compromises for doctors, but continuous cry from the public and pro-universal supporters, amidst government and political impediments, as well as the government not wanting to go against the wishes of the doctors or the people, the government set up a Royal Commission (public inquiry) to explore the issue. Supreme Court Justice, Emmett Hall, was appointed to Chair a Royal Commission Inquiry (Brown & Taylor, 2012) and present its findings to the government.

**Canadian Royal Commission Inquiry**

Justice Hall (1964) held public hearings with constituents. He used a similar format of Abraham Flexner’s (1910) review process in which he visited all medical schools in Canada and the US and some in Europe before writing his report. Hall (1964) visited all the provinces and territories of Canada to learn about their health care systems and needs. He visited and studied the healthcare systems in several other countries. After 67 days of public hearings, meetings with delegates from 406 organizations, and consulting research studies, he presented the final report of the Commission to the government. The primary recommendation is to institute a national health policy with a comprehensive healthcare program for the people of Canada. Hall recommended a focus on three areas for the future of healthcare in Canada:

(a) health services
(b) health personnel, facilities, and research; and
(c) financing and priorities (Hall, 1964; Health Canada, 2015).

His recommendations led to the introduction of the 1968 Canadian Medicare Act (Blishen, 1969; Brown & Taylor, 2012; Naylor, 1986) which is still in effect today. This Act lays out the rules of government-funded healthcare and the responsibilities of the federal and provincial governments for healthcare costs (Canada Health Act, 1968).
The 1968 Act made provision for each province and territory in Canada to administer its own healthcare plan, based on a government-funded model rather than on physician fees for services. The plan must ensure that all people in the province have equal access to healthcare services at no extra cost to the patient. Physicians would bill the government directly for services at pre-determined rates, which as Naylor (1986) points out, effectively wiped out a 200-year history of private billing by physicians and private practice in medicine and replaced it with public practice and government billing for doctors. This has not been a pleasing settlement for doctors in Ontario.

**Medical Associations**

Medical associations play an important role in the make-up of the Canadian medical profession at both the provincial and national level. The provincial associations represent the interests of doctors certified in the affiliated province to practice medicine. The Ontario Medical Association (OMA) for example, is the provincial association for Ontario. It was founded in 1880. It ensures that all Ontario doctors register with the Association. It advocates for the development and promotion of healthcare in the province, listens to the voices of its members, and medical residents in areas such as continuing education, doctor shortage, human resources, billing fees and more. The OMA commitment is to have physicians in Ontario commit to having the healthiest patients and the best healthcare (OMA, n.d.). IMDs are not eligible for membership in the OMA while seeking medical recertification. However, after gaining medical recertification, they become members of the association. The OMA is exclusive to doctors certified to practise medicine in Canada.

The Canadian Medical Association (CMA), which is the Canada-wide organization for Canadian doctors, has a longer history and a greater membership with over 80,000 registered physicians in 2016 (CMA, n.d., para. 3). The CMA is committed to serving and uniting the physicians of Canada. It advocates on their behalf, bargains for the highest standards of health and healthcare and has a vision to be a “leader” in engaging and serving physicians. It remains the national voice for the highest standards for health and health care for all people of Canada (para. 5). One of its values is “bringing diverse communities together to pursue common goals” (Values section, para. 5).
The CMA has fought to uphold ethical standards in the profession since 1849. It was granted “association” status in 1867, the same year as Canada’s Confederation (para. 2). After this 18-years since the start of the CMA in 1849, physicians were ready to move quickly to formalizing the association status. It had already started collaboration with the American Medical Association (AMA) to borrow some of its Code of Ethics and use it as the backbone for the Canadian Code of Ethics (CMA, 2004; Taylor, 1960). This close collaboration between the CMA and AMA made for a special connection and greater synchronization of medical training programs. Up to today, a strong partnership in continuing medical education and in joint medical exams between Canada and America exists. The proximity of the US/Canada border makes this partnership much faster and easier than a link with the mother country or another British colony such as Australia. The adoption of the AMA Code of Ethics by the CMA also further fostered the image of the importance of medical doctors in both countries (Blishen, 1969; Naylor, 1986).

The Medical Curriculum and Students

The medical curriculum for medical education in Canada, originally modelled after the British curriculum, has been shaped and reshaped over the centuries by healthcare professionals and educators. It received regular updates and modifications in collaboration with members of the public, students, health system administrators, government representatives, accreditation bodies, steering committees, and task forces (AFMC, 2012). Factors such as socioeconomic disparity, urbanization, diversity, global mobility, and connectivity contribute to the shaping of medical education and the medical curriculum (AFMC, 2012). Students must understand these factors. Although the existing medical curriculum follows the blueprint of the Flexnerian (1910) model for modern medical education, there has been flexibility to merge it with more recent designs such as the RCPSC (2014) competency-based training program and the CFPC (2011) Triple-C Competency-Based Model and other resources available in individual schools (Crutcher et al., 2011). The educational objectives for specialty residency programs are the responsibility of the regulatory bodies (CFPC and RCPSC). These are distributed nationwide to all medical schools. Since these bodies also conduct the accreditation of training programs at universities, all medical programs in Canada fall under a “one-size-fits-all” curriculum model. Program are expected to abide with these guidelines to ensure successful accreditation by the regulatory bodies. As such, this limits the extent to which programs can re-imagine new programs such as a
diversity in medicine (DIM) program to meet the needs of the growing diverse patient population in Canada.

**IMD Pathway to Licensure Process**

As noted above, each province and territory in Canada operates its own licensing college. These colleges are responsible for setting the criteria for a license to practice medicine in the province but cannot issue licenses to IMDs independently of university postgraduate training programs or passing of the national regulatory exams. Looking at the PGY1 pathway to licensure for IMDs (Figure 4), the structure is complex and becomes very confusing for IMDs, especially when a licensing College such as the CPSO announces it will fast track the processing of IMD licenses (CPSO, 2004). Such comments can be interpreted as: IMDs can have direct route to the College for consideration, independent of the postgraduate training the national regulatory exam.

What is interesting about this pathway for IMDs, compared to the pathway for CIMGs, is the bottleneck at the second and third steps, where the path extends to additional exams. On arrival in Canada, IMDs register with physiciansapply.ca and submit their credentials. Only IMDs with verified credentials can proceed to writing the MCC exam. Everyone is expected to write Part I of the MCC exam, but not the Part II. However, IMDs tend to write Part II of the MCC exam to personally test their ability and to improve their knowledge and preparation for the CaRMS interview. It is a costly exam. Since all PGY1 residents in residency training in Canada must pass this exam before graduating to the second year, this can be a boost to IMDs who pass the exam, thinking that they have reached standards of Canadian residents. However, after passing this exam and the other MCC exam, the challenge to “climb the same tree” (see Figure 1) as other CMGs and CIMGs still looms. The central oval in the PGY1 Pathway shows the spot where IMDs get caught in the recertification process. As discussed earlier, very few IMDs go beyond the CaRMS level of the recertification process.

IMDs who choose family medicine are also required to write the NAC-OSCE—the National Assessment Collaboration (NAC) Objective Structured Clinical Exam (OSCE). The OSCEs are the most challenging exams for IMDs. These exams started in Scotland and, although adopted in Canada, they are not heavily used in international countries. IMDs may be unfamiliar with these exams. However, IMDs who seek extra costly help through places such as the Ontario International Medical Graduate School (2016) do pass these exams and gain access to
the next level of the recertification process as shown in Figure 4. Some may be invited for interviews and granted a retraining program, but the number is small.

In 2011, for example, more than 1,800 applications were received from IMGs (a mix of IMDs and CIMGs), only 191 were selected for retraining. 1,609 were denied a retraining program (Thomson & Cohl, 2011). In the first Iteration Match in Ontario, 6% of Immigrant IMGs [IMDs] were accepted, compared to 20.9% of CSAs [CIMGs] (p. 17). Compared with the CMG pathway in Figure 5, the CMGs’ pathway is almost seamless, and over 90% of CMGs are accepted into postgraduate residency programs.
Figure 5 shows how quickly a CMG can be accepted into a two-year family medicine program, be trained and ready to set up practice of their choice as professional doctors while IMDs must proceed to complete the “pay-back” five-year Return-of-Service contract to the government (Healthforce Ontario, 2016). The acceptance of CMGs for retraining residency is
over 90% (Health HR Group, 2013). Additionally, CMGs are guaranteed a residency training spot if they proceed right after their MD graduation. They start their residency training on July 1st of the year they complete their MD degree and finish in two or five years. For IMDs, the process continues and lingers.

**Canadian Medical Graduate (CMG) Pathway**

CMG Obtains MD Degree from Canadian medical school

- Submits Applications to CaRMS
- Receives invitation for interview at medical school that selects him/her
  - **Receives acceptance** into Postgraduate residency program
    - $\geq 95\%$ acceptance rate
  - **************
- Completes residency training (2 Years FM, 5 Years RCPSC)
- Writes final CFPC or RCPSC exam
- Registers with CPSO for medical license
- CPSO issues medical licence in a few weeks
- Obtains College Membership designation and OHIP number
- Ready to work as independent physician anywhere in Canada of their choice
- Does not have to provide return-of-service in rural community or pay fines to the Ontario government

**Figure 5.** Canadian Medical Graduate (CMG) Pathway.

Figure 6 below displays the vast number of organizations a newcomer IMD is expected to interact with in seeking medical recertification. IMDs are expected to research these organizations, understand the timelines, deadlines, requirements, services, costs and submission
of applications and documentation in a timely fashion after arrival in Canada to avoid falling into the trap of lack of “recency-of-training” (Healthforce Ontario, 2014), which can lead to disqualification. In addition, details on these organizations are in English and/or French on the website. IMDs are required to have a good command of the English language to read and process the information. Access to a computer is almost mandatory to facilitate the process and avoid time lapse during the recertification process.

**Figure 6.** Interplay of organizations.

Source: Association of Faculties of Medicine of Canada (2012).
The Hippocratic Oath and Medicine

The Hippocratic Oath, believed to have originated in 400 BC from Greek medical texts (Tyson, 2003, p.43), has continued to hold a firm place in the medical profession today in Canada and worldwide. The World Health Organization (WHO) embraces changes to the Oath to reflect different medical schools (McNeil & Dowton, 2002). In Australia, Māori students at the University of Auckland read a version of the Oath in Māori. Students in the School of Medicine at the University of Nairobi recite an Oath at graduation. The Hippocratic Oath commits medical doctors to selfless dedication to human life in the practice of medicine.

The University of Manitoba graduated 19 IMDs from the Philippines, Nigeria, and South Africa who had successfully completed the one-year family medicine retraining program. These graduates embraced the Oath at their swearing in ceremony (Calgary Herald, 2016). Universities in Ontario such as Toronto, McMaster, and Ottawa also hold special ceremonies where medical graduates swear to honour the profession and uphold its standards. In a study of the Hippocratic Oath, Dr. Howard Markel (2004), a medical doctor, scientist, and historian, said the following after attending graduation ceremonies for almost 20 years:

Regardless of the language or provenance of the hundreds of texts collectively classified as Hippocratic, on commencement day the historian in me invariably takes a back seat to the physician. Whether I am reciting from bowdlerized or amended versions or the original Greek text, as I rise to take the oath with my peers, my heart grows full with reverence for the profession I have chosen…. It serves as a powerful reminder and declaration that we are all part of a something infinitely larger, older, and more important than a specialty or institution ... as every experienced doctor knows…. As Hippocrates famously said, ‘Life is short, the art long, opportunity fleeting, experience perilous, and the crisis difficult,’ but the legacy of medicine suggests that we are capable of fulfilling this noble-charge. (pp. 2028–29)

What I am suggesting here is that medical doctors, regardless of where they were born and educated, the expectation of reverence for the art and practice of medicine, and an allegiance and selfless commitment to human life should not be too different from a doctor born and educated in a Western country. Markel describes the swearing of the Oath as an affirmation of the profession, an acknowledgment of the “legacy of medicine,” and a “noble-charge” (p. 2029). Because medicine is an international profession, swearing allegiance to the profession does not limit IMDs to practising medicine in their homeland only, or prevent them from transitioning to medicine in other countries. The Canadian medical profession has questioned IMDs’ ability to
engage in education to upgrade to Canadian standards, but it does not provide opportunities for IMDs to upgrade their skills in a school setting and get evaluated and re-prepared to fulfill their duty and allegiance to the profession, even though promised to do so through transitioning to professional careers by the government of Canada.

**Conclusion**

Medicine in Canada evolved from the British colonial model, directly aided by England and the British colonial administrator. The theory and practice of medicine and medical education grew and gained national and international recognition. Throughout its complex evolution leaders and physicians have continuously sought to develop, protect and secure the status, prestige and structure of the profession while at the same time resisting any attempts to lower its professional standards. Medicine originated as an exclusive male-dominated profession. Women, once totally denied access, eventually gained entrance and equal status in the profession after almost 175 years. As the evidence shows, foreign doctors including IMDs, have been less successful in gaining entrance to the homogenous Canadian medical profession. Although there is a shortage of doctors and a growing diversity in the needs of patients, IMDs face greater challenges accessing the profession.

Under the Canada Healthcare Act (1985), the government provides funding support to the provinces and territories to meet the healthcare needs of its people, including all newcomer immigrants, refugees, and other precarious workers and migrants entering the province. At the same time, Ontario medical schools give preference to training local Canadian doctors while continuing to limit IMDs as foreigners into the profession. This chapter provides information on the background and development of medicine in Canada, and the interplay of the various stakeholders and their roles and associations with profession, with the aim to understand how IMDs as foreigners in Canada, may be perceived as a fit into the profession. It is within this context that the issue of governance and representation of IMDs as a constituent group emerge. The next chapter explores the literature that supports this thesis.
Chapter 3

Literature Review

This chapter reviews the literature on the challenges IMDs face in seeking medical recertification and the impacts of the denial of re-licensure on their lives. It builds on the history of the Canadian medical profession discussed in Chapter 2. I explore the sociological and bureaucratic obstacles IMDs face in Canada as foreigners and immigrants in a society that promises equal rights, freedom, and opportunities for immigrant professionals to transition into professional careers (Kenney, 2009). Concepts of cultural and immigrant stigmatization, informal learning, and underemployment are explored. Given that Canada needs immigrants, educated professionals, and their families for economic and population stability, these topics are also explored.

Hindrances to Recertification

Studies have consistently shown that IMDs from developing countries face challenges in terms of foreign credentialing, culture, language, and communication. These challenges affect their suitability for retraining and integration into the medical profession (Bates & Andrew, 2001; Hall et al., 2004; Zulla et al., 2008). A common theme in these studies, primarily from the stakeholders of the profession, is to explore the challenges IMDs face during orientation, retraining, and examinations in relation to Canadian graduates. Based on extensive CaRMS and university postgraduate reporting and comments by university program directors, the MCC and other researchers consistently position IMDs as having deficiencies (see Andrew, 2010; Bates & Andrew, 2001; Cole-Kelly, 1994; Hall et al., 2004; Schabort, Mercuri, & Grierson, 2014; Zulla et al., 2008).

The continuous flow of literature from the profession’s perspective identifies IMDs as unable to cope with retraining and passing the Canadian regulatory exams (Andrew, 2010; Peters, 2012; Zulla et al., 2008). One of the questions I ask: Are IMDs given the appropriate assistance and support to prepare for exams and tests that are designed for Canadian residents? The Ontario Ministry of Health and Long-Term Care (MOHL-TC) heard the pleas of IMDs. In 2010, ministry commissioned George Thomson and Karen Cohl to conduct an independent review of Ontario medical schools regarding IMDs experience in medical recertification. The review showed, among other things, that program directors and faculty are deficient in knowing
how to evaluate and assess IMDs. In response to this comment, the U of T Postgraduate Program (2013) formed a focus group with senior level deans, administrators, and directors to develop a best practices plan for evaluation of IMDs. This plan was meant to better assess IMDs and help the school make better choices in the selection of IMDs, but as Mirchandani (2004) points out, evaluation and assessment of immigrants, have the tendency to further inferiorize them. The fact that more evaluation was determined to be the best practice for selection of IMDs (BPAS, 2013) is good for maintaining the professional, clinical, knowledge, and ethical standards of the profession (Healthcare Act, 1985). The fact that the government pays doctors for their medical services to patients, is worth ensuring that doctors have the knowledge and skills needed. By the same token, there should be other methods to prepare IMDs for these assessments other than just exams and tests. To disqualify IMDs based on their newcomer level of knowledge and skills or arbitrarily decide that all IMDs from non-English speaking backgrounds and developing countries have sub-level skills seems unfair and unjust.

The government funds organizations such as HealthForce Ontario, Touchstone, and other Skills for Change centres at the Young Men Christian Association (YMCA) and community centres in the GTA to serve newcomers, including professional IMDs. However, are these sources sufficient to prepare IMDs for the self-funded costly and time-consuming PGY1 Pathway to licensure (Figure 5) that IMDs must go through? In the changing and diverse communities in Ontario, IMDs’ foreign skills and talents are becoming needed commodities among ethnic patients (Esmail, 2016; Coloma, et al, 2013; Asanin and Wilson, 2008), is this the time to reassess IMDs skills for future patient care in Ontario?

**Canada’s Immigration Policy and Population Mix**

Historically, Canada’s immigration policy has focused on restricting immigrants of visible minority origin as in the case of the Chinese head tax in 1885 (Ninette & Trebilcock, 2010). The goal of immigration was to keep Canada pure and White, with only US, British and Western European immigrants allowed to enter and settle (Ninette & Trebilcock, 2010). With the economic boom after the Great Depression and the Second World War in Canada, a shortage of unskilled labour occurred (p. 321). With Canadians choosing to have fewer children—from 3.93 children per woman in 1959 to 1.49 children in 2000 (Figure 7) and causing population decrease
(Statistics Canada, 2016), the need for people and labor became a growing concern for the Canadian government.

Canada’s need for immigrants to work the land and build its economy after World War I and World War II led to the experience of the biggest influx of immigrants to Canada (Whitaker, 1991; Ninette and Trebilcock, 2010). Between 1902 and just before the First World War in 1914, immigrants hailed directly from England, Scotland, Ireland, Wales, France, and other Western European countries (Ninette & Trebilcock, 2010). This influx increased Canada’s immigrant population by almost 50% to 2.85 million (Boyd & Vickers, 2000) and led to maintaining the dominant British culture in Canada. British immigration and colonial rule maintained the status quo English influence in the development of the country. With post-World War II, however, and the change in immigration policy to the point system (Whitaker, 1991) to attract cheap labour (Ninette & Trebilcock, 2010) and other skilled workers and business class immigrants (Citizenship and Immigration Canada, 2010). The mix of immigrants changed almost completely from the traditional British/Western European immigrants to immigrants from British colonies and developing countries. The point system immigration policy opened its doors and accept immigrants who met the requirements from any country, regardless of race, origin, colour,
creed, racialized and religious backgrounds (Whitaker, 1991). Thus, the start of the attraction of highly educated immigrant doctors from developing countries to Canada.

Scholars and leaders have also advocated for an immigration policy that would be more inclusionary, humanitarian, and capable of attracting highly educated people. They expected professionals such as doctors to immigrate to Canada, bring their families and their relatives so they and their families will engage in education and raise the education standards and expectations of newcomers to fall within highly-educated levels (Ninette & Trebilcock, 2010). No intentional preferences were given to the British doctors as there was no indications that they would decide not to come to Canada or that they might not meet the new immigration requirements. Rather, the assumption was that non-English people from colonies and developing countries would have difficulties meeting the immigration requirements and few from these countries would come to Canada. However, as the ratings show, immigration from Britain fell from 28% to 16%. Immigration from Italy fell from 17% to 3%, while immigration from Asia and the Caribbean rose from 10% in 1965–66 to 23% in 1969–70 (Ninette & Trebilcock, 2010). By 1996 a quarter of all immigrants arriving in Canada, including medical doctors, were of Asian origin, with over 50% settling in Ontaño (Ninette & Trebilcock, 2010). The remaining 50% settled in Montreal and Vancouver (Ninette & Trebilcock, 2010), thus making these cities the most diverse in the country.

By the 1980s and 90s, alterations to the immigration point system reflected the goals of the government’s new Federal Skills Workers Program (Services Canada, 2013), which sought to attract immigrants for high-demand occupations such as medical specialists, family doctors, and other jobs in the medical profession. This further attracted IMDs from non-British, non-English-speaking countries who fall within the “visible minority” category of doctors immigrating to Canada under the Federal Skilled Worker program (Services Canada, 2013). Records show that 74% of immigrants under this program came from different multilingual backgrounds (Statistics Canada, 2011). Almost 10% spoke no English and 50% were professionals such as IMDs with at least one year of professional work experience. Statistics Canada (2013) calculated that 91% of permanent immigrants in the last three quarters were from different parts of Asia, with the Chinese population making up the biggest influx of immigrants in Canada by 2010 (Statistics Canada, 2011).
Also, identified in the literature are the problems and difficult lifestyles of ethnic immigrant patients who speak little or no English (Asanin & Wilson, 2008; Coloma et al., 2013) and do not have access to doctors. Despite this growth in non-English speakers, medical schools continue to focus on producing homegrown English-speaking doctors and limiting access of IMDs to the profession. As the 21st century emerges, people have greater freedom to move to other countries for personal, professional, and social reasons. Students, refugees, workers, and professionals from developing countries continue to enter the country thus further changing the demographics of the patient population and IMDs coming to Canada from non-English-speaking countries.

**Discrimination versus Colonialism**

The Government of Canada claims that there is fairness and equality for all people in this country. It established a new Multiculturalism Act (1985) and the Human Rights Act (1985) to support its claim and continues to support this claim today with the welcoming of over a quarter of a million immigrants, refugees and asylum seekers from around the world. It claims that federal employers, service providers, and public and private companies that are also regulated by the federal government will face serious consequences if caught treating someone adversely or differently in providing goods, services or accommodation. The Human Rights Act (1985) supports that any employer refusing to employ or continuing to employ a person, or treating a person unfairly in the workplace, is subject to charges of discrimination. However, scholars argue that immigrants continue to face racial discrimination in the workplace, society, organizations, and institutions (Dei, 1996; Reitz, 2001; Galabuzi, 2006; 2001; Yosso, 2006). It is questionable whether the medical profession falls under the workplace regulations or under the federal or provincial governments because of its complex involvement with stakeholders from government, universities, associations, and other institutions. An example is provided in the next section.

**Hindrances: Discrimination**

Dr. Arthur Keith is a US-trained psychiatrist who immigrated to Canada in the 1990s and was practising psychiatry in Canada. He was turned away from filling a staff shortage position at Canadian Military Defense. Dr. Keith filed a complaint of discrimination against the CPSO on
the grounds of foreign education and age (CanLII, 2013, #1646) and an appeal against the Canadian Military Defense (Keith v. Canadian Armed Forces, 2015).

In the case against the CPSO, the Commission could not prove discrimination. In addition, evidence presented by Canadian sociologist, Dr. Jeffrey Reitz, who tried to prove that immigrant doctors are subject to discrimination and are denied access to the profession, was counteracted with other evidence showing that a high percentage of specialists born outside of Ontario and Canada engage in the practice of medicine with an even higher percentage practising in Ontario. Dr. Keith did not have the same kind of resources as the court. His claim was further counteracted by the RCPSC with supporting evidence that it did not act on prejudices. The court upheld the evidence of the professional bodies which in turn allows the professional bodies to maintain the standards of the profession and not have to alter their requirements and entrance standards for foreign-trained professionals. Rather, the court describes that even though “discrimination” is defined in the Human Rights Code, it has been “consistently defined by the Tribunal and the courts to mean adverse treatment or a distinction which creates a disadvantage, based on a prohibited ground of discrimination” (CanLII, 2013, 1646, s51, p 66; see also Andrews v. Law Society of British Columbia. [1989] 1 SCR 143). In Dr. Keith’s appeal of Keith v. The Canadian Armed Forces, 2015, his claim was interrogated by case precedents and expert witnesses and opinions.

The appeal was dismissed based on the court’s explanation that “production of documents is necessary for the reason claimed by the Respondent; that the RCPSC policy was a bona fide occupational requirement and a fundamental issue in the Complainant’s claim of adverse effect discrimination (s. 18). According to the courts, if a federal employer such as the Canadian Forces adopts provincially regulated professional qualifications, the hiring standard is subject to scrutiny under the Human Rights Act (1985). It is up to the Human Rights Commission to determine if, in fact, it was a prima facie case of discrimination against Dr. Keith. A similar case regarding a professional engineer who claimed that the Alberta Human Rights Tribunal (AHRT) overlooked procedural fairness because of discrimination was also overturned by the court (see Association of Professional Engineers and Geoscientists of Alberta v Mihaly, 2016 ABQB 61, 2016). The Court of Queen’s Bench of Alberta affirmed that professional regulatory bodies have the right to require foreign-trained applicants to fulfil registration requirements and standardized testing to ensure these foreign trained individuals are competent to practise the regulated
profession safely, but how much testing is fair, unfair, just and not discriminatory? When does the testing come to an end for foreign trained professionals?

The Canadian Charter of Rights and Freedom Act (1982) promises equality to all individuals. Section 5 states that:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, color, religion, sex, age, or mental or physical disability. (Human Rights Code, 1990, s. 5 (1))

Section 15(1) of the Human Rights Code (1990) promises equal opportunities and states:

Without altering the legislative authority of Parliament or of the provincial legislatures, or the rights of any of them with respect to the exercise of their legislative authority, parliament and the legislatures, together with the government of Canada and the provincial governments are committed to:

a. promoting equal opportunities for the well-being of Canadians
b. further economic development to reduce disparity in opportunities, and
c. providing essential public services of reasonable quality to all Canadians (CHRC, 1982, p. 51).

The question, therefore, is: Do IMDs and other foreign trained professionals have to wait until they obtain Canadian citizenship in five or more years before they can start reaping equal opportunities as individuals in Canada? If IMDs must wait for citizenship, they will fall into the lack of recency of training category? How will they be protected by the Canadian Charter of Rights and Freedom Act (1982) and the Ontario Human Rights Codes (1990)? The OHRC make provision for all individuals to receive equal treatment with respect to employment, regardless of culture, identity, education, or language fluency but professional immigrants such as IMDs, and similarly for engineers and other professions, seem to fall short of this protection. The court asks for documents to prove discrimination, but how can individuals provide documents when discrimination can also be subtle and not followed with objective reports or documents?

Take Dr. Amit for example. Dr. Amit, a qualified pediatric specialist of Indian descent in Nova Scotia, had an interesting experience which she shared with MacLean’s magazine. Her husband is of White Canadian descent and a qualified ophthalmologist. They both moved to set up medical practice in a small community in Nova Scotia. He had no problem receiving patient referrals to start his practice. Dr. Amit, however, has an Indian name. She looks Indian and is seen in the eyes of others and from her name as an IMD from Sri Lanka. Unlike her husband, she
had much difficulty receiving referrals to start her medical practice. She worked at the hospital for five years. While she thought of herself as a Canadian in the medical school, she did not know that her name and colour made her an IMD with a foreign accent and culture until the day a family physician stopped her in the corridor at the hospital and exclaimed with a sigh of relief, “I didn’t know you went to Dalhousie! That makes the biggest difference” (Belluz, 2012, p. 1).

Arguably, with these kinds of attitudes, it is difficult to overlook that discrimination against foreign-trained and foreign-looking doctors, students, and staff of colour exists within the walls of the medical institutions and profession. If everyone around you is nice and shows genuine care, or if you are married to a Caucasian and feel welcomed in the society, at what point do you start to think that people of colour are discriminated against? In Afrocentricity: The theory of social change by Asante (1980) asks whether discrimination is a subconscious or unintended reaction, or whether people “parade as Afrocentric but behave un-Afrocentric as hypocrites who do not understand the power they should possess?” (p. 52). I have pondered Asante’s theorization in light of my personal commitment to this study, my participants, and the university administration. Is it hypocritical? How much do people really know and understand a culture other their own? Does learning Chinese, for example, and being able to speak it fluently, mean that one can understand and relate to Chinese culture and idiosyncrasies?

The female physician, Dr. Amit, spoke up about her experience with discrimination at the hospital she worked at, as an opportunity to “orient” physicians to diversity in the profession. Perhaps her decision to bring awareness to the leadership that discrimination/racism is still alive among the members of the profession might gain some attention. If Dr. Amit, however, were an IMD, chances are she might not be working in the hospital. She might not have the same courage to bring her experience to light. She might instead be more concerned about repercussions from the administration and her program director, supervisor, hospital chief, other trainees, and colleagues if she should speak up. She would run the risk of being singled out and perhaps even treated as an outsider or troublemaker, or given disapproval about her behaviour and poor evaluation.

IMDs in retraining programs undergo vigorous evaluation by supervisors, other doctors and professional workers and peers in the training environment. Everyone tries to ensure IMDs receive the critiques necessary to change them into a skilled physician. Any thoughts or
assumptions about being overly watched because of their foreign status would quickly spread among members in the team and can have serious consequences. As such, from personal observation in the profession, IMDs remain silent, unlike Dr. Amit’s response. Taking a chance and speak up like Dr. Amrit would mean taking a chance and risking their training program.

In Part and Markert (cited in Walsh, et al, 2011), one IMD in training said that, as a foreigner, he may be punished if he makes a mistake in assessing the transcultural experiences of patients. Another study shows that two-thirds of doctors in the American societies harbour “unconscious” racial biases toward patients (Association of American Medical Colleges, 2012). Overall, discrimination, race, and racism happen in the medical profession, but taking a stand could mean the risk of confronting a powerful and dominant institution. Just the utterance of these words can easily generate a whole range of emotions in individuals, institutions, and organizations (Dei, 2009). From my experience working at the medical school offices, there were times when leaders and administrators would exercise caution and be very sensitive and politically correct with their choice of words. Other times, they would say it as they saw it.

**Hindrances: Institutional**

The Faculties of Medicine in Ontario accept that the Canadian social contract “requires that IMDs be incorporated into postgraduate medical education” (Thomson & Cohl, 2011, p. 29). They accept that it is a “social responsibility to integrate immigrants into the Canadian workforce” and that they should bring a diversity of experiences and cultures to training programs and to patient care (p. 29). However, when one looks at the statistics and the ratio of diversity in the patient population to the number of IMDs accepted into the profession, the imbalance is severe.

According to a faculty member in Thomson and Cohl's Postgraduate Independent Review, “there are a lot of very good candidates [IMDs]. Nobody really knows the best way to choose [them]” (2011, p. 1). Perhaps there is more truth to this statement than anyone wishes to admit. The U of T Postgraduate Office came up with Best Practices to evaluate and assess IMDs. The working group that was struck to explore the problem was composed of the 17 members as listed in Table 1 (U of T, Postgraduate Medical Education, 2013). Together these members came up with 13 principles from 20 best practices on the selection of IMDs. The 13 principles included ensuring more objectivity, transparency, and fairness in the selection process; better initial
filtering, file reviews, and interviews; better ranking and demonstration of clinical skills; more consideration in the assessment process; and greater validity in cognitive versus non-cognitive selection methods. Better attention to the diversity of residents in postgraduate programs was also included in the recommendations (pp. 9–13). In 2013, a plan for best practices in the application and selection process was rolled out for implementation in 2014. While the plan mentions diversity, there is no mention of increasing the number of IMDs. Diversity seems to mean a mixture of all nationalities in the incoming quota of CMGs and CIMGs, rather than adding visible minority IMDs with foreign skills and talents.

Table 1
Best Practices in Applications and Selections Working Group Membership

<table>
<thead>
<tr>
<th>Deans/Administrators/Directors</th>
<th>Physicians/External</th>
<th>Residents/Clinical Fellows</th>
<th>Research Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glen Bandiera, Chair</td>
<td>Joel Fish</td>
<td>Amanda Cipolla</td>
<td>Mariella Ruetalo</td>
</tr>
<tr>
<td>Caroline Abrahams,</td>
<td>Brad Sinclair</td>
<td>Naheed Dosani</td>
<td></td>
</tr>
<tr>
<td>Jeannette Goguen</td>
<td></td>
<td>Roaa Jamjoom</td>
<td></td>
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<tr>
<td>Maureen Gottesman</td>
<td></td>
<td>Aaron Lo</td>
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<tr>
<td>Karl Iglar</td>
<td></td>
<td>Kevin Shore</td>
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<tr>
<td>David McKnight</td>
<td></td>
<td>Derek Tsang</td>
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<tr>
<td>Leslie Nickell</td>
<td></td>
<td>Zoe Unger</td>
<td></td>
</tr>
</tbody>
</table>

Source: University of Toronto, Postgraduate Medical Education (2013, p. 1).

In addition, looking at the composition of the working group above, representation of minorities or IMD physicians or leaders, who could probably offer a broader perspective on how to better assess IMDs seems to be missing. Is this reflective of Paulo Freire’s (1970) argument that leaders who do not act dialogically impose their decisions on problem solving, thereby overlooking equity and objectivity of the problem?

Culture and Curriculum Change

Yasmin Gunaratnam (2008), a sociologist from Goldsmith University in London, England, conducted a study to determine how health professionals talk about elderly minority ethnic patients in palliative care, and how care is delivered in real-world practice. She used focus
groups in her study. One member commented that doctors could get the textbook stuff (about patients) and understand the meaning and believe that they can go from there to care for patients (Gunaratnam, 2008). Nurses, on the other hand, looked at the delivery of care differently. They focused on culture and religion in the eyes of the patient and not on what they read in textbooks. A social worker in one focus group said, “I think we need to guard against ‘I’ve read the Ladybird book of religion and therefore I know what Muslims want’” (Gunaratnam, 2008).

Cultural understanding cannot be read in textbooks, assumed, or taken for granted. Lack of understanding of a patient’s culture can have a negative impact on the way care is delivered. Universities can look at developing best practices for training doctors in the established Canadian culture and the English model of education, but it takes more than book knowledge to understand patients of different backgrounds, and especially those who lack the English proficiency to communicate with a doctor who seems foreign to them.

JudyAnn Bigby (2003) is a medical doctor and director of the Harvard Medical School Centre for Excellence in Women’s Health at Harvard University. Her patient population is made up of patients from various diverse racial, ethnic, and cultural backgrounds. From her experience with her patients and research on culture and diversity in patient, she contends that:

Physicians should not only be aware of different beliefs or concepts of health and illness, but also become skilled in exploring how or whether these beliefs are important or relevant to a specific individual… physicians should learn to take into account their patients’ personal background (gender, race, ethnicity, and other factors) and their situations in the wider community as a means of providing good patient care to the patients. (p. 10)

Skills in diverse ethnic and cultural backgrounds are skills readily available in first generation IMDs. These cannot be learned easily. Should the profession envision ways to capitalize on these fee resources of IMDs?

In addition, Irby, Cooke, and O’Brien (2010) conducted a follow-up study of US medical schools and teaching hospitals to explore how the Flexner curriculum introduced in 1910 needs to be changed to reflect medicine in the 21st century. They traced Flexner’s steps and style of the study to not veer too far from his methodology for his 1910 study. They resolved that 100 years after Flexner, changes need to be made to reflect the current society of patients, learners’ styles and physicians’ delivery of patient care (Irby et al., 2010). This is also important due to the growing cultural diversity of the patient population. They have made several cautiously worded
recommendations for change in the medical curriculum. These recommendations are designed to allow for a more rigorous and progressive competency curriculum to reflect the full breath of medical education while capitalizing on appropriate and multiple domains of teaching settings to allow medical students and residents to progress the learning curriculum at their own pace (p. 224). Engaging students to work with researchers and innovators in areas such as public health, advocacy, global health, medical education, clinical and translational research are also recommended (p. 224).

The RCPSC and CFPC have already taken the lead in developing competency-based programs (RCPSC, 2011) and tri-curriculum programs (CFPC, 2011) to further prepare doctors and students to be ready to delivery medicine to the patients in Canada. However, capitalizing on IMDs’ skills as first generation immigrants for a more cost-effective care (Bigby, 2003) is not included in these plans to prepare doctors to provide medical care to growing diverse mix of patients.

Lorne Foster (2008) argues that a monopoly exists in the Canadian medical profession and this kind of monopoly stems from historical and political struggles by English doctors to control the profession and keep it under the original English White model (p. 11). Foster argues that there is clear evidence of the Canadian medical profession protecting itself from outsiders such as IMDs with visible racial and foreign identities. He further argues that foreign physicians’ cultural attributes can play a role in the resource planning of the profession. Foster argues that the need to recognize foreign cultures should not be invisible to those who do the judging; “hidden rules,” “unconscious procedures of Whiteness” in the selection process only tends to “distorts the process of recruitment, entry, treatment, promotion, and/or reward allocation in favour of one group rather than another” (p. 3). I do support his critique of the dialectic of culture and power that “culture does not function in a social vacuum” (p. 4), and as Richard Johnson (cited in Foster, 2008) says:

 Cultural processes are intimately connected with social relations, especially with class relations and class formations, with sexual divisions, with the racial structuring of social relations, and with age oppression as a form of dependency... culture involves power and helps to produce asymmetries in the abilities of individuals and social groups to define and realize their needs. (p. 4)
Ramirez, Castaneda, Darder, and Marri (cited in Foster, 2008) also suggest that if individuals can integrate their culture into the workplace, it can bring power into the group. However, if the profession of medicine allows too many different cultures in the profession, the existing dominant culture could be threatened or weakened.

Medicine is a profession that deals with the intimate lives of people that cannot be easily explained or taught and unless the profession is willing to do so, IMDs’ access to the profession will remain elusive (Foster, 2008). Other theorists of cultural studies such as Yosso (2006) maintain that culture is not just the sum of beliefs, religion, language, or communication skills that are built in a person, but rather includes various forms of cultural wealth, such as aspiration, navigational skills, social skills, linguistic skills, family, and resistance. Yosso (2006) argues that cultural traits are not easily copied or taught. As discussed by Asante (1980) as well, they are drawn from the knowledge that individuals such as immigrants bring with them from their homes, communities, and classrooms. The notion that these traits do not occupy theorizing space in the professions and academia denies immigrants’ access to the profession, also promotes social inequality (Yosso, 2006). A comment about Yosso’s articles reads as follows:

As I read the article, I placed the name of one of my students in the margin, Cristina. Her mother and I were sitting in the middle of the parent-teacher conference. We were discussing Cristina’s lack of confidence in her academic abilities. Cristina is a brilliantly talented student. She can literally make anything out of duct tape. She made her backpack, wallet, and even a shirt out of duct tape. She can also out-knit most adults. She taught me how to cast on and cast off in my knitting, something that no adult has been able to teach me. As I shared how impressed I was with her talents, her mom replied, “I have told her this, but her response is, ‘Yes mom, but I am not good at the stuff that is important at school.’”... What will it take to honor the capital that they bring to the table, and what can I, as a classroom teacher do? (Elenitaprdr, 2014, para. 1)

Cultural traits are cited in the literature as a barrier and challenges for immigrant patients and their physicians in healthcare (Rosenberg, Richard, Lussier, & Abdool, 2006). Studies show that patients and/or physicians lack knowledge and understanding of the effects of culture on the doctor-patient relationship, and physicians do not pick up on expressions of distress in their patients (Rosenberg et al., 2006). There is also evidence in the literature that providing culturally appropriate competent care can minimise the barriers immigrants and refugees face in accessing healthcare (O’Donnell, Higgins, Chauhan, & Mullen, 2007).
Overall, trying to teach different cultural knowledge to Canadian doctors in workshops or continuing education may not be as simple as leaders in the profession may think. It is not very easy to teach patients’ cultural identities or cultural competencies in evenings or weekend professional development workshops as Yvonne Steinert (2006) and many other faculty development leaders in the profession are doing and should be commended for doing this in the past 20–30 years. These issues are too deep to grasp in a non-experiential manner because cultural norms inform the identity of a person (Benyamini, Blumstein, Boyko, & Lerner-Geva, 2008). From the patient’s perspective, indeed many immigrants may be able to adjust to Canadian culture, but not everyone can. There are patients and their families who speak little or no English and who could benefit from doctors who speak their language and understand their culture (Coloma, et al, 2013; Asanin & Wilson, 2008). If the physician shortage is a “made in Canada problem,” it should also be a “made in Canada solution” as Wootton discusses (cited in Bennet, 2001, p. 4). Exploring the cultural talents and skills IMDs can contribute to academic teaching, and will be a place to start to meet the government’s promises of accessible healthcare to all people of Canada without distinction of ethnicity. Doctors in Canada are already burdened with heavy patient loads due to the shortage of doctors.

Office of the Fairness Commissioner and AIPSO

The call for fairness and equity by IMDs in Ontario is not a new phenomenon. In 1999, members of the Association of International Physicians and Surgeons of Ontario (AIPSO), established by a group of IMDs, submitted a report to the Regulated Health Professions Act of Ontario about their concerns with unequal access to the profession (Weighing the Balance, 1999). Their report was substantive and called for fairness, accountability, equity, and transparency in how IMDs are treated in the medical recertification process. The report called for equity of IMDs in the Canadian medical system (AIPSO, 1999). Six years later, the Office of the Fairness Commissioner (OFC) was established. The OFC was created by the Fair Access to Regulated Professions and Compulsory Trades Act in 2006 as an advising body to the Minister of Citizenship, Immigration, and International Trade. Its responsibility was to address complaints by international professionals who experienced discriminatory practices and systemic barriers in accessing professional licenses in Ontario. The OFC was also given responsibility to assess the various regulated professions and trades in Ontario. Its other mandate was to look for partialities and unfairness in the professional bodies, develop policies and practices to remove any systemic
unfairness and barriers, and develop policies and practices for fairness and transparency for all internationally trained professionals who are qualified to practice in a regulated profession in Ontario, including IMDs.

The OFC (2010) also advises the regulatory bodies, including the medical regulatory bodies, on streamlining registration practices and provincial government and other regulations to make them more helpful, user-friendly, and discriminatory-free for immigrant professionals. Although it has advisory power, it does not have the power to create retraining positions for IMDs or to place internationally trained and educated professionals into jobs or retraining programs for a license to practice their profession in Canada. It only has advisory capacity, therefore is of little service and assistance to IMDs. Even though it was IMDs whose feedback led to the establishment of this office, IMDs are treated as any of the regulated professions associated with the office.

In 2010, the OFC conducted a survey with a response of approximately 3,800 people from 37 regulated professions (2010, p. 13). The survey focused on better communication and the removal of red tape from organizations and government agencies involved in licensing new immigrants in Ontario. In the report, Fairness Commissioner Jean Augustine highlighted 17 recommendations for improving the way people get their licences in regulated professions in Ontario (p. 6). The recommendations focused on ensuring that professionals do not face unexpected or unreasonable hurdles in receiving certification in their fields (p. 6). She also provided recommendations for “alternatives and mandatory postgraduate training and residency programs for IMDs” to allow qualified IMDs to receive licensure more quickly (cited in OFC, 2010, p. 14). Specific recommendations included:

1. Improving communication between regulatory bodies and applicants seeking licensure in all steps in the process
   a. posting clear information on website regarding timeline, processing time, costs, etc.
2. Giving applicants clear reasons if they are denied a license
3. Streamlining registration processes by reviewing and eliminating unnecessary steps in the process and speeding up decision making
4. Reviewing Canadian work experience requirements for relevancy and compatibility to the profession
5. Enabling potential immigrants to complete steps for licensure prior to arriving in Canada
6. Providing oversight in outsourcing assessment of immigrants’ qualifications
7. Providing alternatives to mandatory postgraduate training and residency programs for IMDs

I decided to follow up with the OFC in 2014 on the progress of these recommendations. I was granted a meeting with the executive director and staff in the OFC office. They were pleased to share the background and operation of the office, the complexities of the myriad of professional bodies in Ontario, and the challenges of breaking through to these organizations to gather information and work with them to fulfill the mandate of the OFC (personal communication, July 11, 2014). They explained their limited success working with IMDs. They met with IMDs. They listened to their concerns and problems but were unable to intervene on the IMDs’ behalf or help them with obtaining licenses or retraining programs. In their opinion, the medical profession is the most complex of the 36 other professional bodies in Ontario (OFC, 2010, p. 38). It was the most difficult profession to gain access to. Commissioner Augustine commended IMDs for passing all the hoops and making it to the interview stage of the recertification process (p. 39) and wished the OFC could be of help IMDs and other professionals if their mandate was not so restrictive.

Overall, the OFC made progress in understanding the different regulated bodies. It defined clear and transparent policies for the application, registration, and training processes of international professionals in Ontario. It continues to work with the medical and other professions in Ontario to ensure fairness and equity for immigrant professionals. In the long run for IMDs, it can offer little services and assistance regarding medical recertification to them.

**Interpreters versus IMDs**

The Government of Ontario provides a budget to hospitals to hire interpreters for non-English-speaking patients (Royal Commission on Health Services, 1961-1964). If a physician or unit needs an interpreter to translate for a patient, they make a request to the office. According to colleagues in medical administration at the Toronto General Hospital, interpreters are expensive. The process of hiring an interpreter involves several administrative steps and synchronizing the
timing of the patient, interpreter and the doctor’s schedule, to ensure interpreter’s availability is a long process. It involves getting final approval to proceed with hiring the interpreter, following up with confirmation, receiving the interpreter and patient on the day, and other internal logistics, but this is not final. The request stays on hold until approved by the budget office. Even if all approvals are received, there is no guarantee that the patient will feel comfortable discussing his or her pain with a stranger. Noted by the Healthcare Interpretation Network (2004, p. 2):

The error rate of untrained interpreters (including family and friends) is sufficiently high as to make their use more dangerous in some circumstances than no interpreter at all. This is because it lends a false sense of security to both provider and client that accurate communication was taking place.

Even if interpreters’ services continue to improve as has been happening in the US (Healthcare Interpretation Network, 2015), I believe one-time-only interpreters defeat the development of a good doctor-patient relationship. Interpreters add a third person to the personal and private care of patients. Why hire interpreters who are not trained in medicine to intervene in the privacy of patients’ lives and risk their confidentiality and future medical/legal issues when educated and trained IMDs can fill this responsibility instead? If family medicine doctors are the gatekeeper and cornerstone to the health system (Tepper, 2015, Section 3, para. 3), I would think the profession can calculate and suggest a greater increase of family doctors to include IMDs to meet community needs to fulfill the mission of the profession.

Educational Wealth and Cost

Reported by the Fraser Institute (2016), by 2012-13 year, the Ontario government had spent $25 billion on education. This represents an increase from $16.7 billion in 2003-04 (Fraser Institute, 2016). It costs an estimated $12,070 per year for public school education per student (Clemens, Van Pelt, & Emes, 2015) and $7,539 per year per university student (Loney, 2014). IMDs who immigrate to Canada generally have received their public school and university education, as well as MD degree and specialist training as evident by the participants in this study (see Table 5). They bring these costly years of formal education, lifelong and informal learning to Canada. Unfortunately, despite the valuable costs of these resources, IMDs’ education and training are deemed disproportionate to Canadian education and training and the
majority of IMDs face devaluation of foreign credentials and skills (Basran & Zong, 1998; Bauder, 2003) after arrival in Canada.

**Learning and Credentialing**

Canada is listed as one of the leading countries in the world for higher education levels, especially among youths 16 to 24 years of age (Statistics Canada, 2008). This statistic does not reflect all students in Ontario. For example, children in Native Aboriginal schools and in poverty-challenged neighbourhoods who do not have the same opportunities will be behind. Canada also makes the claim that its future competitiveness in global markets depends on a highly skilled workforce. With its low birth-rate (Figure 7), the workforce must come from immigrants thus making the Prior Learning Assessment and Recognition programs very essential for skilled immigrants (PLAR, 2006). These programs are designed to identify, recognize and assess academic credentials and formal and informal learning and skills of adults as competencies for the Canadian workforce (Prior Learning Assessment and Recognition [PLAR] Manual, 2006). Other parallel programs have also been established to evaluate immigrants’ formal foreign credentials (also called qualification recognition or QR). However, the practice of medicine which requires specialty education and accreditation does not fall under PLAR to get their credentials assessed for medicine.

The route for assessment of IMDs falls under the costly MCC and physiciansapply.ca programs. The MCC exams were developed in the early 1900s (MCC, 2015) to evaluate doctors and restrict access only to those whose formal degree qualifications equated with the expectations of the profession. For many years, several programs and centres such as the Centre for Education for Health Professionals Educated Abroad (CEHPEA) in Ontario, helped to facilitate the evaluation of doctors, primarily foreign trained doctors, for retraining. CEHPEA also organized the NAC-OSCE for IMDs but once it was transferred to the Touchstone Institute, this service to IMDs ceased. Touchstone Institute now serves visa trainees and international medical graduates (IMGs) who have been accepted for family medicine residency programs Ontario (Touchstone, Education, n.d.) and closes its doors to IMDs.

**Informal Learning**

Informal learning is learning that continues throughout the lifetime of an individual. It takes place outside of formal classroom. It is not graded as part of the education individuals
receive during schooling from kindergarten to university (Livingstone, 1999). Studies show that informal learning represents 80% of an individual learning capacity while formal learning accounts for only 20% of learning (Livingstone, 1999, 2004; Tough, 1968). Tough (1968) uses the concept of an “iceberg” to describe the ratio of the 20% formal learning as visible through official records and school transcripts while the 80% of learning of the individual is buried as in the iceberg and not visible with the naked eye.

IMDs complete their formal education as high achievers in their home country. Usually, children who end up studying medicine in developing countries are those who attended private or boarding schools. It is the children who received good financial and family support and become high performers that end up studying medicine and other professional careers. These are the students who are more likely to attend universities in Africa and abroad as explained by the Deputy Principal of the Mangwaza Boys School in Arusha, Tanzania (personal conversation, July 23–24, 2016). Throughout the school year, private school students become involved in extracurricular activities, outings and excursions where they develop work experience, ethics, survival and other world-view skills and education. These exposures are less available to non-private school children. Moreover, it is likely that IMDs from these countries are privileged with higher education attainment and informal learning skills. Being required to self-prepare and self-study for the Canadian medical exams after arrival in Canada also adds to IMDs’ informal learning base knowledge. Taking this analogy of formal and informal learning, IMDs’ informal learning level is at a much higher level than their formal learning. Yet, there is little mention about capitalizing on IMDs’ informal learning to contribute to the medical profession.

IMDs are asked for Canadian medical experience in the application process. Why ask for this experience if the possibility for obtaining Canadian medical experience is almost nil? From my previous work at the U of T medical school, a very small number of short-term clinical fellowships positions could become available for IMDs. Clinical fellowship experience is “post” postgraduate residency level. Despite completion of post-postgraduate clinical fellowship training in leading residency programs, IMDs must still compete with other IMDs and CIMGs for a retraining position. IMDs also seek observership experience with a practising physician, albeit, at arm’s length to the patient-care contact, to gain Canadian medical experience, but this learning is not recognized by the profession as Canadian experience (Thomson and Cohl, 2011).
Human Capital

Capital in the economic term is the profit and surplus value generated from the actual production and circulation of commodities produced from the worker’s labour. Economic capital goes directly into the pockets of capitalists (Brewer, 1984), but Gary Becker (1964) made the connection between human assets and economic assets and called the human assets, the individual’s human capital. Becker identified human capital as a value that is innate and intangible; a value that can connect with assets such as education, training, work experience, and the ability to contribute to the workplace and society. Human capital asset in turn affects the individual’s future economic outcomes and identity.

Informal learning scholars on the other hand, critique human capital as no longer the mainstream in the workplace. Human capital no longer prepares individuals for the workplace (Livingstone, 1999, 2004, 2009) since knowledge to do the work in the new technological era takes place through on-the-job training. It is argued that a combination of formal, informal, and lifelong learning is necessary for the workplace; that these factors are inter-dependent. In the medical field, significant weight is placed on formal credentialing. Warner (2011) argues that there is a humanistic value in medicine that is fundamental to a physician’s professional identity. Developing this professional identity takes years of learning and practice as the person stays healthy or prepare for better economic outcomes (Becker, 1964). Moreover, the human capital concept can be traced back to 1776 with Scottish philosopher, economist, and social theorist, Adam Smith, in his work, An Inquiry into the Nature and Causes of the Wealth of Nations (cited in Biography.com, 2016, para. 1). Smith used human capital to explain wage differentials between different jobs and workers’ productivity in businesses such as the pin factory. He refers to it as the skills and abilities acquired through labour, work experience, and education. Up to the 1970s, it was much easier to transfer human capital and formal learning into jobs since university education and training were limited to the few who could afford it and were already living in a higher socio-economic class (Livingstone, 2009). However, with technological advances and more people acquiring university education, traditional jobs are no longer available. An education gap is occurring as people have more education than required for the job, thus putting people in the underemployment category if they are unable to find jobs to match their formal education and informal learning skills.
Underemployment

Underemployment occurs when people do not attain employment that matches their education and qualifications. It leads to a wasted workforce (Livingstone, 2004). Although the International Labour Organization states that “each worker will have all the possibilities to acquire the necessary skills to get the employment that most suits them” (1964, p. 1), professional IMDs in Canada lack the opportunities to gain skills and re-education needed to prepare them for employment that suits their professional qualification. Underemployment derived in the US in the 1960s when university students and inner-city people could not find employment to match their university degrees. Students chose to retaliate for change but the phenomenon continued to grow because there were no jobs to fit their qualification. The underemployment rate grew from 25% of university graduates being underemployed or unemployed in the early 1960s to as high as 80% of the entire workforce in the early 1970s (O’Toole, 1975). Lee (2013) calls underemployment “a chronic feature of the labour market” that affects all segments of the population (p. 3).

As indicated in Table 2, the number of IMG retraining positions more than doubled in 2004 (from 90 to 200) but this increase was not intended to remove IMDs from underemployment or unemployment. It was done to accommodate CIMGs who were returning home after completing their medical education in international countries. Table 2 also shows the first time CIMGs were allowed to apply to CaRMS in 2007, to compete with IMDs for IMG positions. Table 3 shows the greater number of IMDs applications to CaRMS in 2015, compared to a smaller number of CIMG applications but more CIMGs having the opportunity to acquire skills and re-education to prepare for employment that suits their qualifications.
Table 2
Amalgamating IMDs and CIMGs

<table>
<thead>
<tr>
<th>Year</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>IMG positions in Ontario almost doubled from 90 to 200. This was not to increase the number of IMDs in the medical profession, but to accommodate CIMGs returning to Ontario from international countries to practice medicine.</td>
</tr>
<tr>
<td>2005</td>
<td>First time CIMGs could apply for second iteration of the CaRMS match</td>
</tr>
<tr>
<td>2007</td>
<td>First time CIMGs were permitted to apply directly to CaRMS match</td>
</tr>
<tr>
<td>2009</td>
<td>IMDs and CIMGs blend together to become one pool of IMDs</td>
</tr>
</tbody>
</table>

Table 3
Example of CaRMS Interaction Distribution, 2015

<table>
<thead>
<tr>
<th>CaRMS Iteration Year</th>
<th>Iteration</th>
<th>Number of Applications</th>
<th>Percentage of all IMD applications</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>1st</td>
<td>6,000 IMDs</td>
<td>75.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>469 CIMGs</td>
<td>24.9%</td>
</tr>
<tr>
<td></td>
<td>2nd</td>
<td>1037 IMDs</td>
<td>78.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>283 CIMGs</td>
<td>21.4%</td>
</tr>
</tbody>
</table>

Conclusion

This chapter captures the overarching trends of literature in the various areas such as hindrances, differences and characteristics impacting IMDs’ lives as immigrant doctors seeking medical recertification and denied such opportunities. The literature points to non-white IMDs as foreign doctors in the system. It supports evidence that discrimination against foreign doctors might exist in the system, whether consciously or unconsciously. The literature shows the circumstances of IMDs living in a vastly diverse multicultural country that needs doctors but considers IMDs as foreigners and unsuitable to fill the need gap.
Presently, there is thin body of literature on what happens to IMDs after they are denied medical recertification. The evidence of devaluation of IMDs’ skills is strong in the literature while plans for professional transitioning in the workforce, capitalizing on formal and informal learning and human capital for employment opportunities are lacking. There is also a thin body of literature on the social inequity, social injustice, and human rights associated with IMDs’ attempts for medical recertification. Optimism for change in the medical curriculum for IMDs is lacking. In closing, much more research is needed to support the gaps in the literature as identified above, and to guide leaders and educators to develop programs and opportunities to stop the suffering and waste of financial and human capital of highly educated IMDs. The next chapter presents the conceptual / theoretical framework that guides this study.
Chapter 4

Conceptual / Theoretical Framework

In this chapter, I seek to discuss the ways in which IMDs’ lack of access and denial of opportunities in medical recertification, come to be articulated through a consortium of theories in this study. My personal journey in the profession with IMDs and the recertification process also adds to my approach. I take as my starting point the historical context of the Canadian medical profession and my personal life as someone who grew up in the British colony of Guyana, currently lives in the former British colony of Canada, and worked in a British influenced university. I use my colonial and anti-colonial lens and my experience with a ‘brush’ of racism while working in a dominant institution, to question the existing structure in the medical profession in relation to IMDs. I come with the perspective of a person who experienced colonization both as a safe place, a place of power relationships and discomforts and a place of neutrality.

To analyze my first research question of what motivates IMDs to immigrate to Canada in light of the impacts on their lives after denial of medical recertification, I examine Maslow’s (1954) hierarchy of needs and motivational theory in Motivation and Personality. To a lesser extent, I include theories of immigration, labour market, supply and demand, and informal learning in conceptualizing this study. I situate these theories in the broader framework of anti-colonialism. To cast a critical gaze (Dei & Kempf, 2006) on the subject, I focus on the access to education and structure in medicine to unpack how visible minority IMDs outside of the British-influenced cultural make-up of the profession are perceived. I set the stage with a discussion of what anti-colonialism means and why I decide to embrace it in this study. I discuss whether power, dominance, and control of the profession play a role in restricting or limiting IMDs’ access into the profession.

It was sensibly suggested by members of my thesis committee that I explore the theories of discrimination and racism elaborated in the works of anti-racist and decolonizing scholars, and that I should challenge the foundations of institutionalized powers and privileges. However, my understanding of the openness and quest for excellence in the profession, and my sociological interpretation of communities, societies, people and IMDs, led me to choose a more constructive method for this study based on opportunities for change.
Moreover, critics may also point out that I often blend my own experiences with those of the participants in this study. I do this as a conscious methodological approach. As I reflect to when I first became concerned about the problems facing IMDs, I remember my initial reaction that change is needed. I remember my initial question of how can we streamline the existing process to get the same people coming to my office (where I was the first point of contact for IMDs), year after year through the system at a faster rate. In time, the conundrum that a structure is needed to uphold and keep order in the profession but simultaneously constrains people (Geertz, 1973) to the extent that they waste many years of their lives, infused my thoughts.

Exploring my position as an agent for change in this study, while also respecting the agency in my participants' lives, I argue that the voices of the participants offer a valid representation of the frequent challenges and hardships immigrant doctors face as outsiders trying to gain access into the profession. I argue that while critical racism is one good way to address the issue of the barriers IMDs face in Canada and the impacts caused on their lives as professional doctors, exploring this problem from an anti-colonial approach with the structural make-up and objectivity of the profession in mind, makes for a stronger examination and re-thinking of change. Thus, I frame this study under the overarching anti-colonial framework with various supporting sociological theories. What follows is a discussion of anti-colonialism, colonial and decolonizing perspectives.

Anti-Colonialism

Anti-colonialism radically analyzes the colonizer’s power and control with references to prominent anti-colonial theorists such Frantz Fanon (2008) and Albert Memmi (1965). Anti-colonialism sees colonial and colonizing relations as imposing and dominating (Dei, 2009). Anti-colonialism has the power of social practice and action needed to survive the colonial and colonizer encounters (Dei, 2000) and interrogates the power configurations of knowledge production (Dei & Asgharzadeh, 2001). Moreover, anti-colonialism seeks to question the complete colonial situation and any aftermaths (Fanon, 2008). It does so particularly with the “saliency of … imperialism that continues to demonstrate lasting effects on marginalized communities” (Dei & Asgharzadeh, 2001, p. 300). If colonialism continues to be produced in relations within schools, colleges, universities, homes, families, workplaces, and other
institutional settings, then it also creates political domination by constructing images of both the colonizers and the colonized (Memmi, 1965). These images aim to sustain hierarchies and systems of power to uphold the medical profession while maintaining authority, control and exclusivity.

Anti-colonial thinking, in addition, interrogates the Eurocentric British educational and professional model of medicine, which forms the root of medicine in Canada, and its applicability to the colonized people. It critiques the oppressive effects of this model on the lives of non-European peoples such as indigenous peoples in Canada who have had their way of life, culture, education, family roots, and identity taken away from them, and have become “foreigners in their own land by way of the colonial encounter” (Dei & Kempf, 2006, p. 130). Although I aim to illuminate the historical trajectory of the profession to contextualize my discussion of the underlying colonialism that contributes to denying IMDs entry into the profession, I do not claim that my perspective of colonialism is the best approach. I claim that the anti-colonialism framework helps to focus and crystalize my discussion in this study (Dei & Kempf, 2006).

The anti-colonial theory of Dei & Kempf (2006, p. 130) hypothesizes that immigrants and racialized minorities are “excluded from/by the dominant pedagogical practices.” It recognizes the international socio-political processes of displacement, improvement, and forced or voluntary migration (Dei & Kempf, 2006). Taking this approach means confronting the works of dedicated educators, leaders, teachers, and strategists who are highly regarded and have committed their lives to the field of medicine, medical education, medical training, and the role of the profession in the health of the public.

Personally, in my years of working in the medical school offices, I very seldom heard words such as racism, discrimination, oppression, or anti-racism. My family, friends, and people I socialized with did not talk about racism or discrimination. My personal upbringing under colonialism and seeing it as the norm for a better standard of living caused me to not question colonialism as a bad thing. Even my personal experiences with racism did not impact my life in a negative way. I saw power and dominance in the profession and various levels of behaviours at the university as the norm. However, during my working life, I observed aversions against
foreign IMDs who could not fit in the “shape” of the profession. Discussion of how to better capitalize on IMDs’ skills and assist them succeed in the program was not as progressive.

Many anti-colonialism scholars discuss the extent of struggle and suffering colonized people everywhere have experienced because of colonization and imperialism. They discuss the dominant powers that rule colonized peoples’ lives (Smith et al., cited in Dei & Kempf, 2006). Dei & Kempf (2006) further explore the different and other subversive ways how people’s minds were colonized by the colonizers through enforced teachings of culture, language, and Eurocentric education. Growing up in Guyana, I experienced life under a colonial style—a life that caused me to turn a blind eye to my cultural heritage and look to everything colonial as having wisdom and better value, but this was totally by choice. On another level, colonization has also had a very detrimental effect on the mental health of the colonized as argued by Fanon (2008). A good example is the impact of residential schooling on the Native Aboriginal communities in Canada.

In an attempt by the colonial government to eliminate the way of life of the Native Peoples of Canada as primitive, Native children were taken away from their families on reserves by the British, and sent to residential schools. This consequently denied parental involvement in the spiritual, cultural, and intellectual development of their children (Truth and Reconciliation Commission of Canada, 2015). By giving these children no choice of indigenous curriculum, content matter, or exploration of their culture or heritage, the European colonizers succeeded in alienating the children from their indigenous heritage. It is only recently, after a hard and serious struggle, that the government has accepted responsibility for historical injustice. Over the past 100 years, Native children, families, and communities have often been left bereft of resources. It is with the recent release of the Truth and Reconciliation Commission report that efforts to create a new relationship between the Native peoples and the government of Canada is becoming possible. Given the costly price the Native peoples have had to pay after decades of being subjected to an enforced English curriculum, foreign language, and Eurocentric culture. Are there lessons to be learned here? Will fostering a Eurocentric and colonial culture in the medical profession take away the different cultural backgrounds and identity of IMDs and patients, and force them into a one-size-fits-all dominant model of medicine and healthcare? Will selecting IMDs with indigenous and ethnic expertise to work with indigenous and ethnic patients serve as a valuable human resource to help deal with and avoid future occurrences of cultural trauma?
Anti-colonial thinkers see it as their goal “to question, interrogate, and challenge the foundations of institutionalized powers and privileges with the accompanying rationale for dominance present in social relations” (Truth and Reconciliation Commission of Canada, 2015, p. 300).

While I worked in the medical school offices, I assumed that the decisions on who got accepted into the retraining programs were thoroughly made by the program directors and interviewers. The U of T motto prominent at the time was to take the “best and brightest” students. However, I remember feeling very confused at times when I received the final rank list for IMDs and felt that it did not represent the best and the brightest IMDs. Mostly, I remember not feeling too surprised when performance issues of these IMDs started to arise.

**The Theoretical Thinking Lens**

While I pursued my master’s degree program, I was exposed to courses on critical pedagogical implications of teaching and decolonization. These courses awoke a new understanding of what colonialism means. They introduced me to new forms of learning, thinking, and questioning of education, teaching style and curriculum. “Whose curriculum is being taught and followed?” “Whose knowledge is being heard, passed down, and continuing to influence the future of medicine?” “Why was the ‘Canadian’ knowledge of medicine the only knowledge taught, and foreign knowledge must remain foreign?” “Why do all doctors have to fit into one mold of thinking when patients and patient care needs are never at a stand-still?” Other courses on anti-racism methodologies, workplace learning, social change, university governance, and the history of medicine drew me into questioning the assumptions about IMDs’ “abilities” that many seem to make. These questions reflected the conditions of IMDs are viewed for a fit into the profession, the dominance and control of education, learning, ideology, and the practice of medicine in a colonial space which further led to “How is this dominant control possible when the universities and other affiliations of the profession claim education for the best and brightest regardless of colour, creed, or social class?”

Questioning the decisions, work, and thinking of the great leaders in medicine, some of whom I had the privilege to work with, has not come easily for me. Approaching my new thinking about IMDs and imaginations for change with players in the medical profession was not simple. I can understand their convictions and pride in delivering the best curriculum and the teaching of medicine at the best university in Canada that garnered international accolades.
However, from a sociological perspective, the works of bell hook’s (1990) and other scholars such as Dei and Kempf (2006), Fine (1994), and Tuhiwai-Smith (1999) on race, racism, decolonization, anti-racism, impacts of qualitative methodologies, and colonial theories also make sense for a critical examination of the problem. As Dei & Kempf (2006) argue, anti-racism refers to a movement that can be locally, contextually, and emotionally charged. It can be deeply personalized and complex and affect people in many ways, but exploring de-racialization of people as the primary object alone in this study will not, I feel, be sufficient to provide constructive help to the situation and action for change.

According to scholars, IMDs face inequality, discrimination, racism, and stigmatization as foreigners, in addition to foreign language, credentials, and culture deficiencies (Reitz, Frick and Calabresse, 1999; Li, 2000; Mirchandani, 2004; Boyd and Schellenberg, 2008; Foster, 2008; Zulla, et al 2008). This has been an ongoing phenomenon. IMDs are treated as foreigners and outsiders of the medical profession. From the early development of the medical profession, British colonials sought to protect the profession from anyone who did not look like, or operate in the same manner as the established norm of the profession. The Loyalist doctors were not English trained and educated. They were denied a license to practice medicine equal to the English style of practice. They were different and unequally educated under different systems of medicine. Even though Loyalist patients needed doctors and could not afford the English doctors’ fees, the Loyalist doctors familiar with their problems were considered not in line with the regulations of the profession. Taking an anti-colonial lens to interrogate the historical problem from the top-down macro structural level, to determine and analyze the problem with the knowledge I gain in this study and existing literature, I focus on a more practical approach to explore the issue with a critical lens. I seek to dismantle any norm of injustices through more open opportunities for IMDs who are feeling oppressed, racialized or victimized.

For example, the current medical system limits the opportunities of IMDs who are willing to pursue retraining or to return to school to gain further education in their specialty. Education to help these IMDs become more marketable for jobs in their fields is restricted because of their status as medical doctors with postgraduate training. It is very unlikely for IMDs to return to medical school and redo the MD degree and residency training due to enrollment and credentialing restrictions. These restrictions lead to termination of IMDs’ life-long professional
medical career and identity as doctors. They restrict their chances for a future medical career in Canada and force devaluation of credentials and livelihood.

The Canadian governments at both the federal and provincial levels have committed to paying the costs for medical care for each patient in Canada, whether Canadian-born, foreign-born, physically or mentally challenged, queer, homeless, inmates, refugees, or of other diversities. The governments and the medical profession commit to providing accessible medical care to all the people with good patient-physician relationships and community-based care. How can these promises be fulfilled if the shortage of doctor continues and education, teaching and training are not reflective to the needs of the patients? Although efforts are made by the profession to ensure that the principles of good patient care are met, the continuing top-down, mono-lingual, mono-cultural, and Eurocentric model practice in the profession will continue to restrict IMDs’ access to the profession as foreigners, thus dispelling any inclusivity of ethnic diversity in the profession. An anti-colonial framework questions the bases of the rejection and selection processes of IMDs in the medical profession.

An anti-colonial framework is also about the affirmation of identities of outsiders such as IMDs while questioning the power relation that exists in the profession. An anti-colonial framework adds divergence to the current structure that dominates a top-down Eurocentric model of medicine. In today’s 21st century global world, with worldview leaders, scholars, and visionary thinkers, change can occur to accommodate diversity of patients and doctors. However, if one remains silent about the issues, nothing will be gained (Dei & Kempf, 2006). One’s research joins the stack of other valuable research that sits on the shelf and collects dust (Berg, 2001) and IMDs’ voices will continue to go unheard.

Dei and Kempf (2006) and Fanon (2008) challenge mental effects caused by colonial education to the colonized. They argue how the delivery of a uni-focal history based on a dominant/colonial control of education has served to amputate marginalized people [such as IMDs in this case] from their past and now into their present. Colonialism further adheres to a policy or practice of acquiring full or partial political control and dominance of an institution or another country and its people. As shown in Chapter 2, the medical profession evolved from British influences and English trained and educated medical doctors. The profession protected the British and English leaders as early as 1763 with the French ceding power to the British. The
colonial government brought the English Royal Charter to Canada and, in turn, gave Canada carte blanche to rule over the people and resources of the land (Egerton, 1908). This gave power to the English and British doctors to develop medicine and do what they thought was best to stabilize the sick and wounded as bodies for labour, war and building the empire were crucial in imperial age.

Anti-colonialism challenges the idea that the colonial encounter has ended. It was past power and dominance that led to oppression of people and enforced colonialism in all the British colonies. An anti-colonialist framework rejects any “post” in anti-colonialism. It asserts that colonial encounters are not just historical, but are trans-historical (Dei & Kempf, p. 130), and that they transcend into foreign boundaries and persist in colonized and colonizing nations. Colonialism continues to prevail in classrooms and educational curricula in schools and universities as well (Dei & Kempf (2006). Colonial practices take the stance that immigrants are racialized minorities who do not fit into the framework of the education model. Instead, they should be thoroughly assessed for inclusion in the dominant pedagogical practices of the profession (Dei & Kempf (2006).

Peters (2012) argues that “anti-colonial struggles provide the opportunity to examine the capacity of individuals as agents, to invoke identity and transcend imposed subjects. These are the marks of colonialism” (p. 1). As per Dei (2004), this identity collectively built through anti-colonial education. Anti-colonialism encourages and requires a shift from the politics of “pity” that define the relationship between the colonized [IMDs] and the colonizers [stakeholders in the medical profession] to a politics that is not based on a “posture of victimhood but on an ethic of courage” (Alfred, cited in Peters, 2012, p. 153). If there is prevailing colonial dominance in a profession, an anti-colonial approach for change engages stakeholders in conscious discourses with the aim of breaking the colonial influences.

Images in the medical profession tend to sustain hierarchies and systems of power that uphold the profession’s authority and control while colonialism makes the colonizers look like they care for IMDs and are doing the best to educate them, as in encouraging them to keep writing the Canadian exams and raise their scores knowing that IMDs are preconceived as having faults and are unsuitable for additional education in the profession. Colonialism exercises devaluation of their foreign credentials, education, and experiences (Foster, 2008). Moreover,
IMDs seem to have “immigrant” stamped onto their credentials. They have the stigma that comes with immigrant status (Borges, 2011; Guo, 2009; Mirchandani, 2004). The notion that IMDs are expected to transform into the image of CIMGs, CMGs, or other Canadian physicians is a form of continuing colonization. It is an agency put into practice to ensure transformation of people (Dei & Kempf, 2006) such as IMDs to fit into a pre-determined mold of culture and medicine.

Since 2009, IMDs and CIMGs are expected to make applications to CaRMS together as international medical graduates (IMGs) seeking recertification in Canada (Thomson & Cohl, 2011). As we can see in Table 3, there is a higher volume of applications from both IMDs than CIMGs with IMDs reaching the 6000 mark for applications to CaRMS in 2015, compared to 469 applications from CIMGs. The CaRMS 2015 results shows one in 30 IMDs was selected for a retraining program, compared to 1 in 4 for CIMGs. This is a real cause for concern. How can so many IMDs be so poorly educated and trained? How can their home-country education and training be so vastly different from the Canadian medical system? Is the profession yoking IMDs with an unequal group of CIMGs and CMGs in the CaRMS match as a further attempt at colonial control of bodies and education? An anti-colonial framework provides the tool to cast a critical gaze on the profession and look for impositions. As Dei & Kempf (2006) argue, to claim that any perspective of education is complete and/or neutral is erroneous; to claim that history is told or taught without specific objectives, whether conscious or unconscious, is inaccurate. People need to acknowledge the purpose and perspective of their teaching or they fall prey to the Eurocentric colonial claim of education (Dei & Kempf, 2006).

The current medical curriculum continues to follow the Abraham Flexner model of evaluating, assessing, and educating doctors to fit into the culture of medicine in Canada (Flexner, 1910). The Flexner model for medical education reinforces the existence of a colonial curriculum (Irby, et al, 2010), albeit in a multi-diverse population of patients. It reinforces the Eurocentric and colonial models of medicine, and, over 100 years later, it continues to have dominance in the education of doctors. This curriculum was probably the best at the time, to the degree that both patients and doctors reflected a more homogeneous population. However, continuing a homogeneous curriculum in a broadly diverse society and patient population, and subjecting IMDs to this kind of assessment seem to further perpetuate colonial dominance and rejecting IMDs from the profession. Dei & Kempf (2006) maintains that anti-colonial thought
working with colonialism and imperialism is “never-ending.” Colonial thought in anti-colonialism can be much more powerful than one can imagine. “It is not just simply foreign or alien” (Dei & Kempf, 2006, p. 3).

Albert Memmi, the renowned Tunisian-French scholar, philosopher, and author of the *Colonizer and the Colonized* (1967), is recognized for his leading work in decolonization and critical interpretation of colonialism. Memmi (1965) describes how Europeans expatriated to the colonies expected to go to picturesque surroundings with better opportunities. They went with the intention to find places where they could speak their language and which were not crowded with their own countrymen; places where there was an administration set up to serve them and an army to protect them. Ultimately, they anticipated better jobs and a better quality of life where they would earn more and spend less. They go to colonies where they impose their way of life, daily habits, and their administrative, political, and cultural inspirations on colonized communities, fixing their gaze on success and becoming rich. Maybe this is not exactly the operations in the medical profession, but as Memmi (1965) further argues colonization is not about the prestige of the flag, cultural expansion, or government supervision. It is not about the preservation of a staff of government employees. Rather, colonization is about the financial basics; that is, the economic advantages that “were preserved” (p. 6) and where the “origin and significance of this profit” must come from others (p. 7). It is about the colonizers’ understanding of discovering their own privileges by taking away that which belongs to the inhabitants, as in the case of the British taking possession of Canada from the Indians to the detriment of the inhabitants of the land (see Canniff, 1894). By this action, the colonizers bring their own laws, beliefs, cultures, and government to the acquired land and make it their own. They can substitute their own rules and laws to usurp power to gain control and profit (Memmi, 1965, pp. 6-7). They can enjoy the reverence and respect of the colonized who are expected to show their faith to the colonizers’ words over that of their own population (p. 12). Moreover, according to Memmi, as a stark demonstration of the power the colonizer has in society is his description of prejudgment of the colonized people by the colonizers.

“Should he [the colonized] ask for or have need for anything, he needs only to show his face to be prejudged favourably by those in the colony who count” (p. 12), whereby as Memmi argues, “looks” count in the colonial society and this is perhaps one reason why IMDs do not readily fit into the medical society. The colonized can also be recruited from among the
indigenous population to receive insider’s favour, but if they appear poor and needy, which may be the case with IMDs, this may affect their acceptance in the colonizer’s group (pp. 13-14). Memmi (1965) further surmised that a person cannot wish to be a colonizer:

[A colonizer is] received as a privileged person by the institution, customs and people. From the time he lands or is born, he finds himself in a factual position which is common to all Europeans living in a colony, a position which turns him into a colonizer…. He could not of course, have sought a colonial experience, but as soon as the venture is begun, it is not up to him to refuse its conditions, if he was born in the colonies of parents who are colonizers themselves (p. 17).

In looking at the historical development of the medical profession and the evolution of medicine in Canada, in comparison with the current structure, make-up and governance of the profession (Chapter 2), there is evidence that medicine continues to be dominated by the traditional dominant influences in its leadership, governance, education, curricula, assessment, and selection processes. This in turn fosters colonialism in the practice of the profession and is another reason why a critical anti-colonial lens offers a critical approach in guiding this study.

From a Colonial to an Anti-Colonial Perspective

As mentioned earlier, I born in Guyana and then moved to Canada for a better life in a more advanced country. This experience of living in two former British colonies and working in an organization influenced by colonial structure has given added insights relating to control and dominance in colonial relations. These insights have come to fuel my interest in an anti-colonial lens to understand the life of IMDs in the profession and the school. In all respects, I accepted colonialism as part of my upbringing. Going to a Christian church, observing strict rules and dress codes, rehearsing the Lord’s prayer and not my Hindu culture and religious ceremonial activities, made me complacent with the colonial experience. Learning to make English foods and dress like the colonials was part of my growing up. When I immigrated to Canada, efforts to assimilate into Canadian society came naturally. Having a job at the university appealed to me. I immediately sought to learn Canadian English to better integrate in the Canadian society and workplace. I saw no reason to hold on to my Hindu culture or Guyanese dialect. Despite my attempts to improve, integrate and assimilate, I was a West Indian woman of colour. I was an immigrant in the dominant culture and structure. Thoughts and suspicions to see the power of
colonialism in the medical school as the problem for IMDs, were at times recognized, but were overcome by a creative and visionary lens to look at how to improve the situation for IMDs.

From my observation of IMDs in the U of T medical school, IMDs tend to make serious efforts to change their communication, language, dress and cultural outlook for easier acceptance and integration in the norms of the Canadian medical system. I remember conversations with IMDs (both males and females) about how to dress for a meeting with a potential program director, supervisor or for a CaRMS interview. Despite these efforts to change and project a Westernized outlook, IMDs fail in the end. Fanon (2008) argues that the colonized such as IMDs or myself, let an inferiority complex take root. They gave up their cultural originality to position themselves in relation to the civilized Western language and culture. They think that the more they assimilate into the cultural values of the metropolis, the more they escape the going down into the grave. In other words, what Fanon asserts, was that the colonized feel the more they prove themselves as better than the others or equal to the colonized, the better their chances of being recognized and seen by the colonizers. They must stay in touch with the metropolis, or they will disappear from reality and their identity. They must also find ways to gain recognition and reassurance from the colonizers (Memmi, 1964). Whether IMDs are made to feel this way or feel suppressed by the structure of the profession, there is also a possibility that traits of colonization or even dictatorship from their homeland, are still imparted in their attitude and behavior to change and be like a Canadian to fit in to the profession. Fanon (2008) argues this kind of behaviour happens in an Antillean “neurotic society.” It goes back to the social structure of society (p. 125). “If there is a flaw [in the structure], it lies ‘not’ in the ‘soul’ of the individual, but in the environment” (p. 133).

There is also a historic inferiority of foreign-trained doctors in the medical profession. Medical acts have been introduced since the establishment of the profession to keep foreign doctors who were not equal to the English standards of the profession, from accessing the profession and practise medicine (see Chapter 2). Again, Fanon blames the environment for this problem and not the individual (p. 116). He argues that the Black man has always been treated as inferior. Because of that, he instead reaches the point of a “superiority complex” (p. 126). Is this what we are seeing among IMDs today? Or is it the structure that imposes gatekeepers to frighten IMDs and create inferiority complex as they struggle with deciding whether to succumb to denial and lose their career and professional identity or proceed in hopes for a good outcome?
There is a need for doctors. The literature shows that IMDs have manoeuvred their lives to integrate by working towards re-inventing themselves to be like a Canadian. Despite this, very few IMDs sprint above the gaze of inferiority complex, imposed on them by the dominant structure of the profession.

On a recent visit to local hospitals in Embu, Kenya, and Arusha, Tanzania, I had informal conversations with hospital staff and medical students. I learned that the hospitals place emphasis on recruiting doctors who can speak both English and Swahili to facilitate doctor–patient communication. These hospitals may be small (Appendix I, J, K), understaffed, and equipped with technology from the 1960s and 70s, but the language of communication between doctors and patients remains a priority. Canada is a bilingual country, yet, as the following figures show, only about half a million people speak French in Ontario while almost three times or 1.5 million people speak other languages (Ontario Communities, 2011 National Household Survey) while the remaining Ontarians speak over 40 different foreign languages and dialects:

- French - 473,315
- Italian - 248,475
- Cantonese - 189,160
- Chinese - 187,160
- Panjabi - 174,875
- Spanish - 173,935
- Tagalog - 161,360
- Portuguese - 146,975
- German - 135,915

1,417,915

After generations of non-English speaking immigrants and refugees arriving in Canada and being encouraged to retain their cultural roots, language and lifestyle under Canada’s Multiculturalism Act, the government provides hospitals with a budget for interpreters to facilitate communication between non-English-speaking immigrant patients and Canadian English-speaking doctors. The Canadian medical profession sees IMDs’ foreign language and culture as deficiencies to the profession and the care for patients. Are these foreign language and cultures really deficiencies or are they assets in the care of ethnic patients?

1. Are patients confidentially and privacy breached with a third person interpreter who is neither a physician nor a medical professional?
2. Is the language gap in the doctor-patient relationship being fully met if reliance is on interpreters?

3. How accurate are the interpreters’ translations of the patient’s concerns and well-being?

4. Why is the government and the medical profession not seeking to capitalize on IMDs’ language and cultural skills to meet the needs of the patient population?

I am not suggesting that all doctors in Canada must learn various foreign languages in order to communicate and care for the patient population. However, as Fanon puts it:

To speak gobblegook to a Black man [or a non-English speaking person] is insulting for it means he is the gook.

Yet, we will be told that there is no intention to willfully give offense. OK, but it is precisely this absence of will- this offhand manner; this casualness; and the ease with which they classify him, imprison him at an uncivilized and primitive level – that is insulting (Fanon, 2008, p. 15).

Canada has had the language resources of immigrant doctors for many decades. Is it time to revisit the gobblegook speaking to ethnic patients and provide better communication services?

Dr. Elijah Anderson, Yale University professor dubbed the “master” Black ethnographer of race and everyday lives of Blacks in America and “barrier-breaker” in navigating pathways into Ivy League colleges in the United States, offers a word of advice. He states that the greatest privilege of graduate students is to ask questions and not having to find answers to them (personal communication, August 22, 2015). I ask many questions in this thesis for which I am unable to provide answers without further research. However, as I search to explore practical possibilities for change and implementation as theorized by Lewin (1946), McIsaac (1999), Weiss (1995), and by others who have proposed best ways to accomplish change for IMDs, these questions are helpful in my conceptualization of the problem at hand. They are helpful in conceptualizing a future action for change.

Irby et al. (2010), commissioned by the Carnegie Foundation for the Advancement of Teaching that appointed Abraham Flexner to study change in the medical curriculum for the 20th century, have already proposed a call for reform of medical education in the 21st century. Ludmerer (cited in Irby et al., 2010) noted that the Flexner curriculum was the “first major transformation” in American [as well as Canadian] medical education. It is often referred to as the “Flexnerian revolution” (p. 222), but as Irby et al posit, they believe that Abraham Flexner “would welcome the foundation’s new critique, undertaken in his spirit” (p. 227). Conversely, I
hope that this new 21st century curriculum goes beyond the focus of medicine as a structure in place to teach medicine to home-grown doctors. I hope that it includes the expanded social and health needs of the diverse patients. I hope it releases the colonial ideology that latches medicine as a “white-privileged” profession.

**Colonial Biases**

The medical regulatory bodies and the university postgraduate training programs are cognizant of the fact that IMDs face stiff competition for retraining residency programs. Moving forward with a leadership plan, Thomson and Cohl (2011, p. 48) suggest:

- More mandatory exams for IMGs (IMDs)
- A new program to further assess IMDs who have scored highly in the exams to prove their competencies with further testing
- Research support and pilot projects to promote IMG (IMD) selection

These recommendations, I feel, lend to further inferiorizing of IMDs’ intelligence. They reflect a subtle intention to ban IMDs from the profession and not necessarily trying to capitalize on their skills or retrain them to work in medical field in Ontario. A new plan of more tests and assessments may achieve its purpose of testing and scrutiny but its rigor could also deter the best and brightest IMDs to the profession. IMDs have already met the eligibility criteria for landed immigrant status, English fluency and professional qualifications to fill job vacancies as specialists and other medical workers as laid out by the HRSDC High Demand Occupation Federal Skills Workers Program (Services Canada, 2013). Are these additional testing necessary? Why are they only focusing on visible minority IMDs from racialized backgrounds and not foreign doctors such as Dr. John Haggie, who is also an immigrant but hailed from England?

Dr. Haggie was schooled and educated in the British system in the United Kingdom but so are many IMDs from current or former British colonies. Dr. Haggie immigrated to Canada in 1994. He was granted a license to practice medicine. He quickly excelled in various professional, political and social positions in Newfoundland and Labrador. He became the Chief of Surgery. He received appointments as Chief of Medical Staff, President of the Regional Medical Association in Newfoundland and Labrador, and then President of the Canadian
Medical Association. Later, he was appointed to serve as the Minister of Health and Community Services in Newfoundland (MD to MHA, 2014; NLMA Staff, 2009). Dr. Haggie could tell the story of his childhood dream and how pleased and happy he was to be in Canada and able to practice medicine and serve the country. I have no intention of diminishing Dr. Haggie’s values or character, but it is the closest example I can find to argue my point that visible minority IMDs from developing countries are not granted the same privilege as Dr. Haggie, to flourish and fulfill their childhood dreams in their new homeland.

**Postgraduate Incline**

I worked in postgraduate medical education offices from the late 1988 to 2008. I was the first point of contact in the training program offices for foreign-trained IMDs seeking medical recertification. IMDs would come directly to my office from the airport, with great excitement to immediately sort out their application for re-licensure and get started with the credential process. Looking back, I believe, without realizing at the time, that I was making deeper connections (Lewin, 1946) with the IMDs as immigrant professionals from visible minority backgrounds. Knowing how slim their chances were for a continuing career and reflecting on my personal fears of insecurity in a foreign country as a newcomer immigrant, I wondered what IMDs would do if they could not gain recertification. I wondered how their families’ lives would be affected.

Every year the CaRMS application process came around, I was reminded of IMDs trying for yet another chance for selection. The situation worsened with the arrival of CIMGs in early the 2000s and with IMDs needing to compete with CIMGs for the same number of IMG positions. I created an information package for IMDs showing the steps to recertification, but this was only helpful to a certain extent as much of the information on policies and procedures for IMDs was changing or not written in policy format. In hindsight, my personal exploration of the challenges facing IMDs originated from inadvertent observations during my work in medical offices and from my interest in promoting the academic institution and medicine. Fifteen years of part-time studies, personal development as a scholar and researcher, many years of administrative knowledge of the profession, and theorization of the data within a framework of anti-colonialism and action research, have led to the recommendations for change as presented in Chapter 10.
Conclusion

Largely, I do not believe physicians, the government, or any of the stakeholders conspire to exclude IMDs from the profession. Instead, I believe conditions have changed demographically, economically and culturally. Consequently, if Abraham Flexner’s 20th century model for change of curriculum for a modern society sustained the profession for over one hundred years, change undertaken in a similar spirit to sustain medicine in a culturally diverse society, inclusive of IMDs and all groups of people, would be new and innovative change in the 21st century.

Diversity in the Canadian population will likely not go away for some time. To support it, we need to teach diversity and inclusion in medical schools for the better of all these processes. We need to continue the excellent faculty development and continuing medical education for practicing doctors as offered by the profession. We need to include teachers and presenters with specific innate cultural and linguistic skills. Accepting more IMDs into the profession would contribute to the individual’s professional development and better contributions to Ontario’s healthcare and economy. This would provide added international resources to the Canadian medical profession for further enhancement of teaching, research and medical practice. Swaying in and out of various theories on motivation, race, discrimination, immigration, and economics, with the focus in an anti-colonial framework with structure and agency, I believe I give credence to this study. I believe I bring to the forefront, the voices and issues facing IMDs for further reflection and discussions to tackle the diversity and social justice issues for betterments of various stakeholders of the profession. Rather, situating the experiences of IMDs in an anti-colonial framework with Lewin’s (1946) theory to explore change to solve a long-standing problem is a step in the right direction. It also helps to focus on the need to capitalize on international skills to further advance 21st century medicine and patient-care in Canada.
Chapter 5
Methodology

The chapter is organized into six sections, beginning with the rationale for using qualitative research approach and a grounded theory approach. The rationale includes discussion of the issues involved in conducting a study with highly educated doctors who were under no obligation to answer personal questions. The second section explains how I recruited and selected the 15 participants. In the third section, I discuss the methods I used for collecting the data and, in the fourth section, the process of analyzing the data. The analysis began to reveal the challenges IMDs face after denial of recertification and prompts for ideas for possible changes to the IMD problem. The last section discusses questions of validity, ethical considerations and limitations to this research, followed by a brief descriptive narrative of each participant.

Research Approach and Considerations

Sociologists Glazer and Strauss (1967) were convinced that quantitative research theories were often inadequate for a good understanding the participants in a study. In response, they developed a “qualitative design in sociology” (Creswell, 2007, p. 63) as an alternative research approach. This development led to many books supporting the power and value of qualitative research, and presenting a framework and methodology (e.g., Creswell, 2007; Lincoln & Guba, 1985; Strauss & Corbin, 1998). Since the 1960s, qualitative research has become an increasingly accepted form of social and critical inquiry.

Using qualitative research in this study has been important for several reasons. First, as Strauss and Corbin (1998, p. 60) explain, it enables researchers to collect data while also “learn[ing] to wait for the data to speak to them.” As this study involves the personal and lived experiences of IMDs, waiting for the data to “speak to me” was valuable and helped me to listen for new meanings and answers to my questions. Second, it helped me to “ground” my data, particularly as it involves the actions, interactions, and social processes of my participants (Creswell, 2007). Third, qualitative research is an iterative process. Using open-ended questions in interviews helps researchers make observations on the culture, context, reflections, and interactions that emerge from people’s life experiences and, in the process, gain a deeper understanding of human knowledge. Fourth, qualitative research enables researchers to organize mutually agreed-upon interviews in conducive and natural settings to help participants be at ease
during the data collection (Creswell, 2007). As Denzin and Lincoln (2003) state, different from quantitative research, qualitative research helps researchers build reliable and trusting relationships with participants that allow their personal reflections to emerge. For example, I used an icebreaker in my interviews to discover what motivated the participants to come to Canada. This question encouraged reflection, self-analysis, and discussion of positive and negative experiences, including the excitement IMDs feel in preparing to come to Canada, their pride in starting a new life, and the pain in failing to achieve their goals.

As a qualitative researcher, I am interested in the life experiences of IMDs. I am interested in finding out how IMDs’ lives are impacted after they are denied the possibility of practising medicine in their new homeland, what they do, and what I can do to make their voices heard in resolving their problems. Interviewing professional doctors who have studied medicine and some of whom have had leading professional roles in their home countries can be awkward for a researcher. It can also be awkward for the participant if the researcher touches on sensitive issues about personal life, finances, marital relationships, family, and more. These types of questions can be a zone of vulnerability for participants (Creswell, 2003). They can raise and spin emotions out of control, especially if the researcher probes to gain a better or deeper understanding of what the participant is saying (Creswell, 2003; Glazer & Strauss, 1967). However, had I decided not to use qualitative research, I am certain that a large part of the study would be meaningless. Qualitative research methodology allows the researcher to pick up valuable cues and gestures helpful in bringing out the meaning of the data. This methodology allows me to collect data on the motivational, economic, professional, and personal challenges IMDs face. Focusing on these areas during the interviews, helped participants reflect on and make sense (Berg, 2007) of what they were thinking and saying from their unique perspectives.

Grounded Theory

Grounded theory is a research tool that enables researchers to seek out patterns in interview data through constant reflection, comparison, and conceptualization (Glazer & Strauss, 1967; Geertz, 1973). It is the approach I used in this study. Using grounded theory in the data collection process with my participants added richness, meaning and validity to my data. The process enabled me to reflect on what participants had said in earlier interviews with what previous participants had said, and then build on, or rephrase questions to delve deeper into the
meaning of an emerging or persistent phenomenon until clearer understanding is reached. Grounded theory led to a systematic and flexible way of collecting and analyzing the data and constructing “theories ‘grounded’ in the data themselves” (Glazer & Strauss, 1967, p. 7). As such, it gave me the freedom to remain open to ideas, theories, and the voices of my participants, to learn more about their unique experiences before forming opinions.

The ability to encourage participants to be open and honest with themselves and with me as the researcher, adds value, credibility, uniqueness, and reliability to the data (Fine, 1994). This in turn yields sounder empirical evidence. It can also lead to the emergence of new knowledge in areas such as equity, freedom, and justice through the voices and collective struggles of participants in their professional lives (Dei, Mazzuca, McIsaac, & Zine, 1997).

**Research Questions Design**

Developing research questions for a qualitative study is one of the most crucial components of interview design (Creswell, 2003). The questions should have a good balance of breadth and specificity to help researchers achieve what they want to learn or understand (Maxwell, 2005). As discussed in chapter 1, I first drafted the questions with input from my supervisor. Having this broad list of questions was helpful as it brought my initial focus for the study together (Charmaz, 2006). It also gave me the starting point for conceptualizing the bigger picture of the study (Maxwell, 2005) and prepared me for the two focus groups of IMDs that would contribute to refining the questions further (Table 4).

**Table 4**

*Focus Group Participants*

<table>
<thead>
<tr>
<th>Participants</th>
<th>Sex</th>
<th>Age</th>
<th>Country</th>
<th>Status</th>
<th>Total hours by each participant</th>
</tr>
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<tbody>
<tr>
<td>#1</td>
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<td>30–35</td>
<td>South America</td>
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<tr>
<td>#2</td>
<td>Female</td>
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<td>Africa</td>
<td>Resident</td>
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<tr>
<td>#3</td>
<td>Female</td>
<td>30–35</td>
<td>Egypt</td>
<td>Fellow</td>
<td>1</td>
</tr>
<tr>
<td>#4</td>
<td>Female</td>
<td>30–35</td>
<td>Egypt</td>
<td>Student</td>
<td>2</td>
</tr>
</tbody>
</table>
The focus group participants were from different countries, had different medical specialties, and were at different points in seeking medical recertification in Ontario. One member was from Colombia. He was unemployed at the time and fully committed to learning Canadian medicine and rewriting the exams until he achieved a retraining residency position. The second member was accepted for a retraining residency program at a university in Ontario and was a current resident. The third member was in the process of completing a postgraduate clinical fellowship program while preparing for the Canadian medical exams. The fourth member was the sister of the third IMD and was in the process of preparing to rewrite the Canadian medical exams while pursuing a Master of Health Sciences degree at U of T.

I presented the focus group with my initial list of 18 questions and many prompts for each question. The first focus group meeting lasted approximately one and a half hours, with one person acting as moderator. The group suggested revisions to the questions and recommended places where further review of the literature was needed to clarify the questions. A second focus group meeting of approximately one hour took place with three members. One member acted as the moderator and together we derived the research questions for the study.

Research Questions

1. What motivates IMDs to immigrate to Canada?
2. How does being denied medical recertification impact the lives of IMDs:
   a. Professionally, as a professionally trained doctor in a new country?
   b. Personally, as a single individual or an individual with a family and family responsibilities?
   c. Socially, as a person living in Canadian society?
3. Reflecting on the experiences of IMDs in Canada, what one or two recommendations would you make to improve the medical recertification system?

I then arranged a pilot testing and mock interview with two people from different backgrounds. The first mock interview was with one of the IMDs who participated in the focus group. The second was with an undergraduate student. I explained the purpose of the interview to both participants, used the interview protocol (Appendix B) to welcome and develop a rapport with them, and explained the consent form. I asked each participant to read the consent form and let me know if they had questions. Based on their feedback, I modified the consent form slightly to clarify a question (Appendix C). Overall, the pilot test helped me to see if there were
weaknesses in the interview design. It allowed me to make necessary revisions prior to implementing the study (Kvale, 1994). My proposal received clearance by the U of T Ethics Research Board.

Sample Group

The logic behind using a sample of subjects in a study is to be able to “make inferences about some larger population from a smaller one” (Berg, 2007, p. 41). The size of the sample and the participant selection process are crucial to the success of the study. I chose two different strategies to recruit participants: purposive sampling and snowball sampling.

For the purposive sampling, I selected participants who were known to me, had knowledge about being an IMD, and represented the demographic of participants I sought for the study (Berg, 2007). Because I worked at a Canadian medical school and had contacts with IMDs and physicians, using purposive sampling gave me the chance to connect with people I already knew. The snowball strategy allowed me to recruit participants whom I had never met and, thus, remove any biases. I also used a list of criteria (Fine, 1994) to ensure the sample included only IMDs denied a license to practice medicine in Canada, meaning have met the requirements for application for a retraining residency, but were denied a retraining position.

Recruitment

I printed advertisements (Appendix D) in colour and posted them on bulletin boards in the U of T libraries, medical buildings, education faculty (OISE), and other communal spaces on the downtown campus. I also posted them in Toronto teaching hospitals such as Women’s College and the University Health Network, local coffee shops where possible, and the Kaplan Centre on Bloor Street where many international professionals attend English classes. I also emailed the advertisement with an introductory message to different groups of IMDs whose contact information I had received from friends, professors, and physicians. I asked people to forward the advertisement to other IMDs they knew. All potential participants who received the advertisement or heard of the study through the snowball effect had the opportunity to self-select for participation in the study before contacting me (Creswell, 2007; Glazer & Strauss, 1967).

I explained the purpose and format of the study to each participant, and reviewed the eligibility criteria (Appendix F). I purposely limited the selection of participants to two from any
given country to ensure the sample reflected the diversity of IMDs in Canada. Only participants who met the criteria as listed in the advertisement were considered to participate in the study. Recruitment and selection continued until I felt I had reached a saturation point in terms of yielding rich and detailed data for the study (Creswell, 2007; Geertz, 1973; Glazer & Strauss, 1967).

**Featured Characteristics of Participants**

The characteristics of the participants in the study are listed in Table 5 and Table 6. From my assessment in the interviews, they were all fluent in English. While the majority were very confident with their fluency and competency in English, three felt that their language skills might be a hindrance. However, they were good and I did not need an interpreter. I had no difficulty understanding their responses. Some of the participants, although from non-English speaking countries, had done their formal education in English. Tallying up, altogether, the participants spoke eight foreign languages fluently. Twelve, or 80%, were married and had at least one child. One female IMD was married and had no children. Two IMDs, or roughly 13%, lived apart from their spouses, who were also medical professionals. They amicably agreed to live separately to ensure that at least one parent maintained a professional medical career and was a role model to their children.

Anonymity and confidentiality were very important to the participants, especially to avoid jeopardizing future applications for a retraining residency. They did not want to appear “ungrateful” or as “complainers.” The IMD community is a small community where people know each other. Releasing their identity could affect their relationships with peers. To preserve anonymity, I folded their countries of origin into larger regions and gave each participant a pseudonym. Seven participants were male and eight were female. Three of the men were single. One of these three men moved back to his home country after several attempts at recertification. The participants’ children ranged in age from four years old to teenagers.
Table 5

*featured characteristics of study participants*

<table>
<thead>
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<th>Feature Characteristics of Participants (N=15)</th>
</tr>
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<tbody>
<tr>
<td>Language</td>
</tr>
<tr>
<td>Although their mother tongue was not English, 11 participants were educated in English and worked and lived in English communities</td>
</tr>
<tr>
<td>Social marital status</td>
</tr>
<tr>
<td>10 = (67%) Married with children</td>
</tr>
<tr>
<td>2 = (13%) living separately from spouse (1 male and 1 female)</td>
</tr>
<tr>
<td>3 = (20%) Single. One returned to his home country to continue practising medicine</td>
</tr>
<tr>
<td>Age distribution</td>
</tr>
<tr>
<td>3 = 35–39 (20%)</td>
</tr>
<tr>
<td>6 = 40–44 (40%)</td>
</tr>
<tr>
<td>4 = 45–49 (20%)</td>
</tr>
<tr>
<td>2 = 50+ (20%)</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>7 = Male (47%)</td>
</tr>
<tr>
<td>8 = Female (53%)</td>
</tr>
<tr>
<td>MD/Equivalent</td>
</tr>
<tr>
<td>15 (100%)</td>
</tr>
<tr>
<td>Medical specialty</td>
</tr>
<tr>
<td>Anesthesia (1); Emergency medicine (1); Family medicine (6); Medicine (1); Ob/Gyn (3); Orthopedic (1); Surgery (3)</td>
</tr>
<tr>
<td>Medical practice experience</td>
</tr>
<tr>
<td>0–28 years</td>
</tr>
<tr>
<td>Time living in Canada and not working as a medical doctor</td>
</tr>
<tr>
<td>1.5–25 years</td>
</tr>
</tbody>
</table>

**participant demographics flow sheet**

An at-a-glance flow-sheet providing more general information about the participants is this study is presented in Table 6 while a short narrative with more information on each participant are appended at the end of this chapter.
### Table 6
*Overview of Participants’ Demographics*

<table>
<thead>
<tr>
<th>Name</th>
<th>Male/Female</th>
<th>Marital Status</th>
<th>Age Range</th>
<th>Year Arrived in Canada</th>
<th>Associated Continent</th>
<th>Specialist status</th>
<th># of Years of MD Degree/Equivalent Training</th>
<th># of Years Practice in Medicine</th>
<th># of Years in Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1 Dr. Enzo</td>
<td>M</td>
<td>Married</td>
<td>35-39</td>
<td>2009</td>
<td>Europe</td>
<td>Orth Surg</td>
<td>6</td>
<td>6.5</td>
<td>4</td>
</tr>
<tr>
<td>P2 Dr. Flora</td>
<td>F</td>
<td>Married</td>
<td>40-44</td>
<td>2005</td>
<td>Asia</td>
<td>Ob/Gyn</td>
<td>5</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>P3 Dr. Artmad</td>
<td>M</td>
<td>Married</td>
<td>45-49</td>
<td>2009</td>
<td>Asia</td>
<td>Gen Surgery</td>
<td>5</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>P4 Dr. Tila*</td>
<td>F</td>
<td>Married</td>
<td>45-49</td>
<td>1990 MD 2009</td>
<td>Asia</td>
<td>Fam Med</td>
<td>4.5</td>
<td>0</td>
<td>(25)*</td>
</tr>
<tr>
<td>P5 Dr. Vera</td>
<td>F</td>
<td>Married</td>
<td>40-44</td>
<td>2007</td>
<td>Europe</td>
<td>Fam Med (Emerg)</td>
<td>6</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>P6 Dr. Stella</td>
<td>F</td>
<td>Married</td>
<td>35-39</td>
<td>2007</td>
<td>West Indies</td>
<td>Ob/Gyn</td>
<td>5</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>P7 Dr. Maboo</td>
<td>M</td>
<td>Single</td>
<td>40-44</td>
<td>2006</td>
<td>Middle East Fam Med</td>
<td></td>
<td>7</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>P8 Dr. Seena</td>
<td>F</td>
<td>Married</td>
<td>45-49</td>
<td>2005</td>
<td>Africa</td>
<td>Ob/Gyn</td>
<td>5.5</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>P9 Dr. Gerty</td>
<td>F</td>
<td>Married</td>
<td>40-44</td>
<td>2001</td>
<td>South America</td>
<td>FM</td>
<td>6</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>P10 Dr. TFox</td>
<td>M</td>
<td>Single</td>
<td>50+</td>
<td>2005</td>
<td>Europe</td>
<td>Ob/Gyn</td>
<td>6</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>P11 Dr. Arju</td>
<td>M</td>
<td>Single</td>
<td>35-39</td>
<td>2009</td>
<td>Africa</td>
<td>Fam Med</td>
<td>6</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>P12 Dr. Eddie**</td>
<td>M</td>
<td>**Married</td>
<td>45-49</td>
<td>2010</td>
<td>Africa</td>
<td>Fam Med</td>
<td>7</td>
<td>6.5</td>
<td>3</td>
</tr>
<tr>
<td>P13 Dr. Kripp</td>
<td>M</td>
<td>Married</td>
<td>50+</td>
<td>2004</td>
<td>Africa</td>
<td>Surgery</td>
<td>5</td>
<td>28</td>
<td>9</td>
</tr>
<tr>
<td>P14 Dr. Tunde</td>
<td>F</td>
<td>Married</td>
<td>40-44</td>
<td>2012</td>
<td>Africa</td>
<td>Fam Med</td>
<td>6</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>P15 Dr. Menita</td>
<td>F</td>
<td>Married</td>
<td>40-44</td>
<td>2005</td>
<td>Middle East</td>
<td>Surgery</td>
<td>7</td>
<td>3</td>
<td>8</td>
</tr>
</tbody>
</table>

Average number of years IMDs live in Canada →

6 @ 1.5
9 @ 5+

Total number of years of MD/Equivalent Training of IMDs →

87

Total number of years IMDs practice medicine in prior to coming to Canada →

139

Total number of years IMDs live in Canada & not practicing medicine →

82.5

*Note.* *Dr. Tila’s medical education interrupted due to civil war in her country. She resumed her studies at a University in the West Indies and obtained her MD degree in 2009.*

**Dr. Eddie is married but living separate from his wife as a way for one parent to maintain their professional medical license.*
Data Collection

Data collection in qualitative research relies on various methods including self-reflection, which engages participants in an interactive and humanistic way. Ensuring a setting that is conducive for the interview is important. In trying to understand the IMD issue, I explored opportunities to observe IMDs in their settings beyond the university environment as noted in Table 7.

Table 7

Observation of IMDs

<table>
<thead>
<tr>
<th>Place of Observation</th>
<th>Location</th>
<th>Day of Observation</th>
<th># of Hours of Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMD Symposium day-long conference</td>
<td>Toronto Metro Convention Centre</td>
<td>October 2012</td>
<td>5.0 hours</td>
</tr>
<tr>
<td>IMD Symposium day-long conference</td>
<td>Toronto Metro Convention Centre</td>
<td>October 2013</td>
<td>5.0 hours</td>
</tr>
<tr>
<td>Kaplan Centre for International Graduates</td>
<td>Toronto</td>
<td>March 27, March 28, April 1, 2013</td>
<td>1.50 hours</td>
</tr>
<tr>
<td>Open Study Group</td>
<td>St. Michael’s Hospital</td>
<td>April 2013 (3 visits of 2 hours each)</td>
<td>6.0 hours</td>
</tr>
<tr>
<td>The Ontario IMD School</td>
<td>University of Toronto</td>
<td>May 18, 19, 26, June 23, 2013</td>
<td>15.0 hours</td>
</tr>
<tr>
<td>Total Hours</td>
<td></td>
<td></td>
<td>32.50 hours</td>
</tr>
</tbody>
</table>

The IMD Symposia at the Metro Convention Centre in Toronto were particularly interested. There were several hundred IMDs at these sessions. The panelists at the Symposia consisted of deans, the CaRMS president, representatives from the MCC, medical schools, and other national organizations and special keynote guest speakers. In the dimly lit packed room with glaring LCD lighting for PowerPoint presentations, the messages were clear: Immigrant doctors have training and skills unequal to Canadian standards, there are only a few positions available for IMDs, and the competition is stiff. The contrast between observing IMDs at these
 symposia and at their study group or the IMG School with prior approval was stark (Table 7). At the study groups and the IMG School, IMDs seemed more energetic, engaged in their studies and confident in themselves. They asked questions and engaged in discussing cases and having lively discussions. These visits gave me a glimpse of IMDs’ enthusiasm in a study setting and added depth to my research (Berg, 2007).

I interviewed 15 IMDs who self-selected to participate in the study and met the eligibility criteria (Appendix D). I interviewed them in mutually agreed environments on a one-on-one basis using open-ended semi-structured questions (Appendix F). On March 28, 2013, I conducted the first interview at the U of T St. George campus. I moved into self-reflection of the “here and now” during the interview, which seemed difficult for the participant initially, but quickly changed to a more positive experience of memories and soul searching. The open-ended questions and semi-structured interview format enabled me to interject to gain clarity and keep the focus on professional, personal/family, and social life experiences. I also used the first interview to gather insight on how participants will respond to the questions and how I can do the transcriptions and analysis. I used it to get an idea of the themes emerging from the data in the aim of building, refining, and redefining the questions (Berg, 2007; Creswell, 2007).

During the interviews, sometimes the interviewees seemed a little distracted or embarrassed to respond, especially to probes if they were getting too personal. This made me feel somewhat unsure about the questions, but overall, I believe I weighed the situations carefully. I maintained respect and appreciation for the participants throughout the process. At times, I interjected for clarification or to answer questions but not to discourage participants or redirect the interviews. There were also times when participants told stories about an experience that did not fit with the questions. I listened carefully to try and contextualize the stories as they related to the experiences of the participants. As well, because I recorded the interviews with the participants’ permission and transcribed them immediately after, I looked for errors in my questioning and clarified any suspicions or speculations I might have had. I modified the questioning to bring out themes emerging from the interviews. By the tenth interview, the three major themes of the question—professional, personal/family, and social impacts—had emerged as important topics to all participants. Other themes that emerged strongly were economic concerns, social injustice, discrimination, lack of transparency and clarity in the recertification process, lack of professional opportunities, loss of identity and status, impacts on emotions, health and well-being, fear, stress,
victimization, outsiders, and frustrations. These themes continued into the 11th and 12th interviews, at which point I thought I had reached saturation (Geertz, 1973), but I continued with the three more interviews. The themes remained almost the same with the 15th interview.

The last question I asked the participants was what would be one or two recommendations they would offer to the profession. Since IMDs’ voices are seldom, if at all, included in decision making or strategic planning in terms of policies and recommendations, this was a rare opportunity to gather their ideas. Their recommendations are included in Chapter 9 of this study. The duration and type of interview with each participant is shown in Table 8. The shortest interviews were the telephone interviews. This does not mean that they yielded less value or less useful information. On the contrary, I gathered significant and valuable data from both these interviews and the longer ones.

Table 8

*Participant Interviews: Duration and Format*

<table>
<thead>
<tr>
<th>Participants</th>
<th>Duration of Interview (minutes)</th>
<th>Interview Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1 Enzo</td>
<td>90–100</td>
<td>Face-to-face</td>
</tr>
<tr>
<td>P2 Flora</td>
<td>90–100</td>
<td>Face-to-face</td>
</tr>
<tr>
<td>P3 Artmad</td>
<td>90–100</td>
<td>Face-to-face</td>
</tr>
<tr>
<td>P4 Tila</td>
<td>90–100</td>
<td>Face-to-face</td>
</tr>
<tr>
<td>P5 Vera</td>
<td>90–100</td>
<td>Face-to-face</td>
</tr>
<tr>
<td>P6 Stella</td>
<td>60</td>
<td>Telephone</td>
</tr>
<tr>
<td>P7 Maboo</td>
<td>90–100</td>
<td>Face-to-face</td>
</tr>
<tr>
<td>P8 Seena</td>
<td>90–100</td>
<td>Face-to-face</td>
</tr>
<tr>
<td>P9 Gerty</td>
<td>90–100</td>
<td>Face-to-face</td>
</tr>
<tr>
<td>P10 TFox</td>
<td>90–100</td>
<td>Face-to-face</td>
</tr>
<tr>
<td>P11 Arju</td>
<td>90–100</td>
<td>Face-to-face</td>
</tr>
<tr>
<td>P12 Eddie</td>
<td>90–100</td>
<td>Face-to-face</td>
</tr>
<tr>
<td>P13 Kripp</td>
<td>60–100</td>
<td>Face-to-face</td>
</tr>
<tr>
<td>P14 Tunde</td>
<td>50–55</td>
<td>Face-to-face</td>
</tr>
<tr>
<td>P15 Menita</td>
<td>60</td>
<td>Telephone</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>13 face-to-face</td>
</tr>
</tbody>
</table>

Throughout the interviews, the participants were calm and professional. They were given the right to interrupt, ask questions, and opt out of the interview at any time for any reason. I made special efforts to ensure that the interview process was comfortable and convenient. I
ensured that all participants understood the interview protocol (Appendix B). I created a non-threatening, non-intimidating space with good lighting, and created a good rapport to avoid any power dynamics between us. I steered away from a “sitting-across-the-desk” style of interview (Kvale, 1994) to remove any authoritative position and help create a parallel collaboration. I felt free to contact the interviewees after the interviews as needed to seek clarification of the data (Strauss & Corbin, 1998).

**Transcription**

After interviewing each participant, I listened to the full audio recording of the interview to gain a fuller understanding of the questions and the responses. I then listened to the recording again while I transcribed the interview leaving a two-inch right margin for notations, pauses, laughter, and any other tones that might seem important to reference. I re-listened to the recording to fill in any blanks. This was important because I engaged in considerable analysis of the first interview and each subsequent interview during the transcription to ensure the questions were asked in a non-threatening way, with consistency, and in a relaxed tone with few interruptions when the participant was speaking (Simon & Goes, 2013). Because I applied the same evaluative and thick description process to all the interviews (Geertz, 1973), I could study the data with what I remembered of the body language of the participants—their voice, tone, mood, high and low points, and other clues (Simon & Goes, 2013) to better understand the transcription.

While transcribing, I also used NVivo software to create themes and cross-referenced the data. During the transcription, it was also easy for me to develop color codes and thematic headings for the data and code and theme the data during the transcription phase.

**Theoretical Sampling**

As I coded and analyzed the data, I tried to determine the emerging inter-relationships into a theory (Glaser & Strauss, 1967). I used theoretical sampling to develop major categories based on the themes highlighted in the research questions of the study. I used a constant comparison method to closely analyze the data and put aside any data that were not relevant or did not fit into the research objective.
Data Analysis

After transcribing the interviews verbatim, doing member checking, referencing, coding and theming, in consultation with my supervisor and committee, I examined the first question on motivation and how it manifested in IMDs as newcomer immigrants to Canada seeking medical recertification. I referred to the literature, field notes from my observations, newspaper clippings, news reports, journal articles, and critiques of theories. I reviewed these with the transcription data in mind and applied Geertz’s (1973) thick description method to gain a deeper understanding of the data that revealed the issues IMDs face in Canada. Sometimes during the interviews, I felt interviewees were getting a little distracted and seemed embarrassed to respond questions, especially those related to probes and if they were a little personal, but I think I weighed the situations carefully. I maintained respect and appreciation for the participants throughout the process, interjected appropriately to clarify or answer questions. There were also times when participants told stories about an experience that did not fit with the questions and I might interject again to redirect them to the interview. However, I tried not to interject in a way to discourage them. Rather, I felt I needed to listen and try to contextualize their stories as related to their life experience. I then created a second round of coding to remove repetitions and other externalities and focus on the connections that the participants made to the theme of motivation and their life experiences after being denied a retraining spot. During this process, I connected with my supervisor, committee members, and other colleagues to get perspective and guidance on the codes I had chosen. I then finalized the codes to reflect issues of motivation, economic quandaries, and impacts on IMDs’ lives after denial of medical recertification.

This process of listening, putting my pen down, and observing while I tried to gain a deep understanding of the stories and experiences added more value to my data. As I transcribed the recordings, I could visualize moments in the conversations and make more sense of them. As Strauss and Corbin (1998) wrote, “It is our analytic eyes that lead us to see, imperfect as that seeing might be” (p. 55). By assigning codes to the data, I gave meaning to pieces of data while, at the same time, grouping the data into categories to identify a concept or a central idea (Silverman, 2000).

The NVivo software enabled me to add, remove, change, and store codes easily. It also allowed me to go back and forth between the text and the audio recording to clarify any text that
seemed obscure or did not make sense. It provided the option to view all major and minor codes in ascending or descending alphabetical order, or in side-by-side columns in the textual documents or audio recordings. I could prepare a list of notes for data that I felt had mixed meanings or did not quite fit into any of the primary or secondary codes.

I often reflected on what my data said in comparison to the existing literature, the media, the profession, and other reviewers. I also kept in mind my personal experiences and understanding of the medical profession and what had pushed me into giving up more than 10 years of my adult working years to pursue this study of IMDs. Being a creative and innovative thinker and doer, a person who believes in “imagining the possibilities,” I looked to the data to speak to me about new ways of solving a long-standing problem (Strauss & Corbin, 1998). Therefore, while coding and analyzing the data, I kept reducing it to reflect the conceptual framework and research questions of the study (Creswell, 2002). Because I used open-ended and probing questions, I had collected a broad range of data. Keeping the conceptual framework and the questions in mind, I excluded data that were not relevant to the study. More reduction happened when I began to summarize the codes and construct themes, but I was careful not to lose data that could make a difference to the outcome of the study. I used inductive analysis to allow patterns, themes, and categories to emerge from the data (Mason, 2002). In the end, I had over 100 primary and secondary codes that I used to further analyze and theme the data. I did not include input from the interviewees on the data or the interpretation of the data. As such, the data are interpreted solely by me as the researcher.

**Confidentiality of Data**

Confidentiality was foremost in the minds of many of the participants. To assure them of confidentiality and anonymity, I reviewed the purpose and protocol for the interview. I highlighted the confidentiality clause on the consent form (Appendix C) and asked all participants to read the consent form and sign it if they agreed, before proceeding with the interview. The signed consent forms are stored in a locked cabinet in my home office. All the audio interviews were deleted after the transcriptions were completed. The data for this study are in a secure locked location until they are erased or destroyed in accordance with the protocol of the U of T Ethics Review Board (U of T, Research and Innovation, n.d.).
Confidentiality and anonymity were important to the participants for both professional and political reasons. One IMD, for example, signed the consent form and completed the interview. Shortly after the interview, she called me to meet with her. She expressed concerns with the interview. She was very concerned that colleagues, family, and community members in Canada and in her home country, which was on the news in Canada and America, might recognize her. As well, because medicine is still a very male-dominated profession in her homeland, she was concerned that if her gender and country were mentioned, people would recognize her and know that she participated in the study. She asked to be removed from the study. Respecting her wishes, I destroyed my notes and erased the recording of the interview. Further, as most of the participants were expecting to reapply for retraining residency programs in Ontario medical schools, they were concerned that their participation in the study would jeopardize their chances. They wanted to participate in the study, but did not want to be recognized by the program directors or seen as speaking against the profession.

**Corroboration of Data—Triangulation**

Triangulation is the use of multiple and different data sources, investigators, and methods to support the overall research design and the argument a researcher wants to construct (Denzin, 1998; Mason, 2002). Through triangulation, I could strengthen and enhance the data, and gain a deeper understanding of the issues I was researching.

I used in-depth individual interviews as the major source of data. The interviews were complemented and corroborated with secondary data, documents, documentaries, and media news to give a holistic picture of IMDs in Canada and the vastness of the medical profession. They were also augmented with data from my observations and field notes, and from the focus groups I conducted. The perspectives, opinions, and data obtained from the participants were strictly from their own lived experiences. Bringing these various sources of information together has lent to a very rich and interesting data set.

**Validity and Reliability**

Validity and reliability lend credibility, accuracy, and dependability to the data and the study (Lincoln & Guba, 1985). They are best achieved through the triangulation of information from different sources. The combination of data from the interviews, focus groups, reports,
books, documents, policies, and procedures helped to correct any errors in my findings. I also conducted additional interviews with one or two successful IMDs, and with the executive director of the Ontario Fairness Commission. Because of my previous knowledge of IMDs and the medical profession and my interest in immigrants and children living decent lives in Canada, I took further steps as a researcher to avoid any possible biases in the study. Several critics, including Kvale (1994), argue that the notion of absolute objectivity on the part of the researcher needs to be questioned. I can attest that even though I had some knowledge of the internal operations of the profession due to my work in the medical school, I tried to maintain an objective view of the data always in the study.

I hired a PhD student from Goldsmiths University in London, England, to work with me and to ensure a more independent and objective viewpoint. I provided her with the first two interview transcripts and asked her to read them through and write down the major themes that came up. She shared the themes with me, and they were similar to the themes I had found. I gave her another set of three transcripts to do the same. Again, her findings were similar to mine. After she completed the tenth transcript, we stopped the process. I also hired a transcriber for two of the interviews to ensure the objectivity of my transcription of the data. Her transcriptions were very close to mine. She returned the transcripts to me along with a spreadsheet of the themes and codes she had identified in the process.

Another method of reliability involves recoding earlier transcripts in the study. I went back and reviewed the codes on some of the transcripts and then went back and recoded a random selection of transcripts. I checked my second coding against the original coding. There were some differences, but overall this process was instructive and brought “definitional clarity” (Miles & Huberman, 1994, p. 64).

**Ethical Considerations**

As a qualitative researcher studying human subjects, I must adhere to the ethical requirements of consent, confidentiality, and taking care. As mentioned above, this was particularly significant for me because the participants in my study belong to a closely-knit network. Mentioning the name of the country they are from, the number of children they have, their current job/occupation or their spouse’s occupation, could give assumptions and reveal their identity and association with this study. IMDs were adamant about keeping them anonymous and
I sought to respect my participants by being vigilant about details and identifiers that may link to their identity. I kept all data and information about the study and participants protected and private. I reminded the participants of their choice to withdraw from the interview at any time.

Some researchers have argued that a power relationship between researcher and participant is inevitable in qualitative research (Fine, 1994). As I have had previous experience with IMDs and the Canadian medical school and medical profession, it was more advantageous for me to collaborate with participants. This way, I could report ethical and sincere findings that would benefit the IMDs and the profession.

The participants retained control of the interview process, including the right to withdraw or refuse to participate at any time with no questions asked (Creswell, 2003). Overall, they remained open to the interviews, probably because they needed to speak about the issues, or because I used probes and searching questions, or both. Some expressed gratitude to me for conducting this study and giving them a chance to have their voices heard.

**Limitations of the Study**

Berg (2007) and Creswell (2003) argue that research that seeks to give voice to the experiences of participants rather than to generalize or universalize their voices, generally has limitations. I acknowledge that the sample of participants in this study is limited and not reflective of all, or a larger sample of visible minority IMDs. A bigger group of participants from a broader list of countries, varied age ranges, a wider range of medical specialties and economic self-sufficiency, would have expanded the validity of the result. A comparison of total funds IMDs bring to Canada, how much they spend on exams, what the income earnings are while continuing to seek medical recertification, alongside IMDs who accepted termination of professional medical career and engaged in employment, as well as the classification and status of their jobs, may provide more explicit facts about financial and economic losses of IMDs. I would have liked to discover the leading reasons that guide IMDs to accept termination of medical career, to remove any generalization that these IMDs are poorly trained and educated. However, the participants who self-nominated for this study represents a good sample to answer the questions designed for this study. Their experiences with medical recertification in Ontario seem representative as being a good predictor of other IMDs across Canada.
I also indicated earlier that the medical profession consists of a complex body of stakeholders with vested interests and viewpoints. This, in combination with the complexity of the medical recertification process itself, made conclusion of analysis and findings more inconclusive. What I came to see in this research, is the extent to which the ‘objective’ procedures in the profession are based on social constructions, evaluations, and the interactions of stakeholders. Some procedures seem discriminatory and racialized and draw from historical practices that have systematically undervalue doctors trained under British colonial systems in developing and non-English-speaking countries such as India, Kenya or the West Indies. Others stem from the power of a male-dominated profession that saw women as inferior and incapable to engage in medical education and the practice of medicine. I address these issues throughout this thesis. What follows is a narrative profile of each of the 15 participants in the study.

**Descriptive Profiles of Study Participants**

**Participant 1: Dr. Enzo**

Dr. Enzo is an East European surgeon who, at the time of the interview, was between the ages of 35 and 39. He was interested in medicine from a young age. After receiving his Doctor of Medicine, he won a prestigious national competition in his country for a four-year sub-specialty residency training. He immigrated to Canada after reading that there was shortage of doctors. He thought his extra specialist training would give him an advantage. He met his wife who is also a medical professional and was seeking re-licensure in her field. They have a young son. Dr. Enzo continues to work in various jobs while continuing to study for the Canadian exams. He earns a total salary of about $26,000 a year. He feels that he has lost four years of earning power. He depleted the finances he brought to help him with securing medical recertification. He has no other source of funding and is not eligible for a bank loan to seek a different career. He feels like a “prisoner” in this country and “victimized” because he is foreign born and has a foreign doctor of medicine degree.

**Participant 2: Dr. Flora**

Dr. Flora is an East Asian Indian physician who practised family medicine for seven years before immigrating to Canada. She was 40 to 44 years old at the time of the interview. She
passed the Canadian medical exams and the US MLE exams with high marks. She speaks fluent English. She has met the requirements for the CaRMS application process seven times in seven years since arriving in Canada in 2005. She spent almost $20,000 on exam fees and preparation. Her husband is a self-employed entrepreneur whose business has not been doing well. Every year she gets invited for a CaRMS interview but has consistently denied a retraining position. She immigrated to Canada because she heard there is a shortage of doctors and was looking for better professional and educational opportunities and her children. Canada is a more peaceful and safe country and while it is important for her family to pray and eat together, she cooks all her meals which takes up a lot of her time, but she still finds time to study and able to pass the medical exams, including the NAC-OSCE. She compared her situation to back home, where she had a driver to take her everywhere, a big house, and family vacations abroad every year. Doctors in her home county earn a very high salary. Now she lives in an apartment and does not have a job after being in the country for seven years.

**Participant 3: Dr. Artmad**

Dr. Artmad is an East Asian Indian general surgeon and a humanitarian by nature. He practised general surgery in his home country for 15 years before coming to Canada in 2007. He and his wife, who is also a medical doctor, and three sons moved to Canada. He had some friends and relatives and received some assistance from them to get settled when he arrived in Canada. Dr. Artmad was the Chief of Surgery at his hometown hospital. He owned his own private clinic, employed 15 staff, and worked there together with his wife. He wrote the Canadian exams at the age of 50 after being out of medical school for over 20 years. He is a quick learner. With some orientation to the system and some upgrading to learn the different tools, drugs, set-up, and culture of Canadian medicine, will be sufficient training for him. He did not feel he needed a full five-year retraining residency in surgery. Since arriving in Canada, he applied for Canadian medical experience through clinical fellowships, clinical assistantships, and observerships, but has not been successful. He currently works as a security guard and earns a salary of less than $30,000 per year. With his experience as a senior doctor, administrator, and leader in his medical specialty in his country, he wants to do more. He is disappointed that Canada treats professionals in such a way. At his age, it is too late to switch to another profession and compete with younger students. Medicine is all he knows and can do.
He has volunteered for a mission in Africa and, on his return to Toronto, is going to the UK to check out the possibilities there for medical work. He will move anywhere in the world to practise medicine and avoid a gap in his clinical experience, but it is expensive to do so on his income. He spends evenings and weekends studying at the library or coffee shop while his wife has the sole responsibility to raise their teenage sons. He believes they see their father as “hopeless” because he cannot find a job in the medical field even though he passed the exams and meet the requirements for a retraining position. He feels that no one “believes” that he was once a doctor. While he is not casting blame on the system or pass judgment, he has been very upset at the unfair treatment and testing that hurt IMDs very badly. He came to Canada for safety and for himself and family. He won’t give up fighting for his career.

Participant 4: Dr. Tila

Dr. Tila is of East Asian Indian descent and 45–49 years old. Her childhood dream, as well as her parents’ dream for her, was to become a doctor. She started her Doctor of Medicine degree at a medical school in Sri-Lanka, but the university and school were forced to close because of ethnic violence and bombing nearby. Her MD degree was cut short. She later got married and immigrated to Canada in 1990. While her son was still young, and with the approval of her husband and parents, she continued her studies at the St. George Medical School in the West Indies (2005–2009). This was a very expensive degree. In addition to transportation and accommodation costs, she paid $5,000–6,000 USD per rotation for her internship training in the US. She completed an elective in psychiatry and counselling. Having missed the 2009 MCC exam deadline by just a little bit, she had to wait for another year to write it. This was a long wait for her. She looked at the Physician Assistant program as a second option, but found it too expensive and the job outcomes did not look promising. She later found a research position at St. Michael’s Hospital with an oncology doctor. She thought this job, plus her Canadian electives and American internship, her experience in one of the biggest teaching hospitals in Toronto, and the fact that there are almost five million people in Canada who do not have access to family doctors would give her fewer problems than more recent IMDs in getting a license to practice medicine, but it did not work. Since graduating in 2009, her husband has had a heart attack. She does not have a medical license, her son is a teenager living at home, and she has not had a full-time job in Canada since immigrating in 1990. She wanted to study medicine. She did and now she is trapped.
Participant 5: Dr. Vera

Dr. Vera was born and educated in Eastern Europe. She was between 40 and 44 years old at the time of the interview. She is married with no children. She completed a six-year Doctor of Medicine degree in Eastern Europe and postgraduate training in family medicine. She also completed a fellowship in emergency medicine. She practised medicine for 10 years (five in emergency medicine and five in rural medicine) before immigrating to Canada in 2007. She chose to immigrate to Canada because she thought she would have better opportunities to fulfill her desire to learn more about medicine and practice medicine in a more advanced and educated country. She also came to Canada for better financial and lifestyle opportunities. She heard that Canada is a beautiful and fair country. She felt that there were limited opportunities back home and heard that Canada accepts immigrants from all countries and that it has a need for doctors. Her application was accepted with no problem. She went to the HealthForce Ontario to gather more information. She said it “breaks her heart” to see so many IMDs at the centre. Many have been in Canada for many years and are still hoping for a license to practice medicine. She made connections, studied hard, wrote the Canadian exams, and organized study groups for her colleagues to help them out and create a support network. She found the support network helpful for herself as well. As she began to see what it is like to pass all the exams, meet all the requirements, submit applications to CaRMS, and not be called for interviews, she realized that the challenges IMDs face are no fault of their own. Dr. Vera has a calm and sharing spirit. She tries to help other IMDs. She is optimistic that her turn will come. She said:

I have crossed the wide ocean to get here. I won’t give up easily. I have to try everything possible. I don’t mind the training. I will take as much training as they think I need even if I must pay for it from my own pocket.

Participant 6: Dr. Stella

Dr. Stella was born in the West Indies and is of Indian descent. She pursued a five-year Doctor of Medicine degree in the West Indies. She graduated in 2001. She also completed a postgraduate specialty in obstetrics/gynaecology and practised Ob/Gyn in the West Indies for four years before immigrating to Canada in 2007. She and her husband both had very good jobs as practising doctors in their hometown. They were told there is a shortage of doctors in Canada and that the country needs young people with families. Dr. Stella was excited to move to Canada. She saw it as a beautiful multicultural country where her family would fit nicely, especially in
the summer with the Caribbean celebrations. Her parents were strict. Her mother was a strict teacher who used the “wild cane.” Her father worked for the medical planning department in the government. He wanted her brothers to be doctors, but they ended up in politics instead. When she became a doctor, her parents were very happy. They were even happier when she introduced them to her future husband who was also a doctor.

They enjoyed the social life, community, and outdoor life in the West Indies. Her parents were not very happy with her decision to move to Canada with her husband and family. They received their landed immigrant status, sold their home, gave up their jobs, packed their bags, gathered their family, and flew to Canada. They wanted to ship some of their household furniture and other things to their new home, but decided that obtaining medical licenses was their priority. They settled in the city and were very happy family. Her husband was very keen on developing an international collaboration with medicine in Canada. Dr. Stella was more interested in exploring the Canadian medical system and practice Ob/Gyn. Six years after arriving in Canada, neither she nor her husband have been successful in obtaining a license to practise medicine. She works at Tim Horton’s serving coffee. He is living in a small town where no one knows him as a doctor.

**Participant 7: Dr. Maboo**

Dr. Maboo is family medicine doctor. He was born in the Middle East and immigrated to Canada in 2006. He was between 40 and 44 at the time of the interview. He completed a seven-year Doctor of Medicine degree in his home country in 1993, with a speciality as a general practitioner. He practised medicine for 13 years before immigrating to Canada. He was still a very young professional doctor when he arrived in Canada, seeking to learn new knowledge and advances in medicine. He was looking for more opportunities in the profession. He felt a little uncomfortable making the move, but decided to take the chance. His immigration application took a long time. While he was waiting, he did research on the internet to learn more about Canadian medicine and the process for obtaining a license. He started to study for the exams before immigrating. It took about four years for his immigration application to come through. He checked the news in Canada and the job market for doctors regularly. He did not want to come and not be able to work as a doctor. After arriving in Canada, he immediately sought out the licensure process and started to write the exams. He did not have a family and had more time to
focus on gaining recertification. He wrote the required qualifying exams for IMDs in Vancouver. He was willing to move anywhere in Canada where there were jobs. He passed the exams, applied to CaRMS, but was denied an interview. During this long and complicated process, his savings were disappearing. He worked at a shipping dock and then later at a printing shop to earn money to survive. He tried to reach out to program directors for assistance and guidance on how to prepare better for the IMD selection, but was not successful. Juggling work, personal life, time for studying, and figuring out the process was becoming impossible, complicated, and very frustrating. After four to five years of studying and passing the exams, not being given a retraining position, unable to figure out what he had done wrong, and feeling confused and frustrated, he decided to give up and return to his homeland.

**Participant 8: Dr. Seena**

Dr. Seena is an East Asian Indian obstetrics and gynaecology doctor. She was 45–49 years old at the time of the interview. She immigrated to Canada in 2005. She obtained her five-year Doctor of Medicine degree in 1987 and pursued postgraduate specialty training. She practised in her field for 10 years before immigrating to Canada. She was chief of the gynaecology department and resigned from that post one year before immigrating to Canada to prepare a Plan B for when she arrived. She commenced a distance education master’s degree in Health Management at the London School of Hygiene and Tropical Medicine. This extra education made her the only IMD in the study with a high-paying non-medical professional job in a clinical setting. She works on several committees in the hospital helping to develop plans for patients, but what she really misses is interacting with patients and practising medicine. Working in a hospital setting, she came to know many of the key players in the profession. She sought advice from them. They told her to “try again next year,” which means rewriting the TOEFL, QE, and the NAC-OSCE. These are numerous exams to study for and write in one year. The CaRMS application is also a complicated and very expensive process. Dr. Seena is worried that she will make all this effort again this year and still not be selected. All her efforts will be in vain. She is very upset that Canada says it needs doctors, especially in underserviced areas, but that when IMDs pass the exams and want to practise in those areas, the profession says they are not good enough. She asked me, “where is the justice in this”?
Participant 9: Dr. Gerty

Dr. Gerty is a 40- to 44-year-old female family physician who arrived in Canada in 2001. She obtained a six-year Doctor of Medicine degree from her home country in South America and continued with postgraduate training as a family medicine and general internal practitioner. She practised family medicine for 10 years before arriving in Canada. She is married. Her husband is an engineer and owns a business in Canada. They have two children (14 and 12). They would like their children to have the best education and Canadian experience. They speak fluent English. Dr. Gerty personally did not want to come to Canada. She had a thriving medical practice, a big car, a house, helpers for the cooking and cleaning, and a very high-class lifestyle. She enjoyed her job, family, and social life, but she and her husband wanted more opportunities for their children. Dr. Gerty enjoys taking the children to football and soccer after school. She wants to spend more time with her children doing social activities. She wants to help with the family business which was their primary source of income, but she needs to focus on passing the exams and plan the CaRMS application process every chance she has. Her life is totally engulfed by the exams and worrying that her marks remain high. Her husband and children encourage her to keep trying, but after so many years of trying with no feedback, it gets very discouraging. She sees doctors at work in the clinic and knows she could do the same job, probably even better, but she has to follow the rules. She is tired and exhausted. She feels very frustrated most of the time, and knowing that she may never make it makes her very depressed.

Participant 10: Dr. TFox

Dr. TFox is between 45 and 49 years old. He was born in Eastern Europe. He completed a six-year Doctor of Medicine/equivalent degree and an additional subspecialty program in obstetrics and gynaecology in his home country. He practised medicine for 10 years at home before immigrating to Canada in 2005. He was 40 years old and single when he arrived. His primary reason for immigrating to Canada was because he wanted to learn new knowledge, new advances in medicine, and seek out other opportunities in his profession. He wrote the LMCC exams in his home country before immigrating to Canada under the Federal Skilled Workers program. From a very young age he loved sports and was involved in competitive sports. In high school, he was advised by his doctor that he was no longer strong enough to engage in sports. Around the same time, Terry Fox visited his country. He was inspired that people in a Western country like Terry Fox could have the opportunity to continue training for a run across the
country and no one stopped him. He (Dr. TFox) could not do what Terry Fox did in his country. The Terry Fox story encouraged him not to give up and inspired him to immigrate to Canada for professional opportunities and freedom to explore and do what he wanted to do. Almost 10 years after arriving in Canada, and almost at the age of 50, he has written the Canada exams and applied for residency, but has never been offered a retraining position. He is still single, cannot go on dates, and does not have a family, a home, a car, or a job. He worked on different projects in labourer jobs. Today, he is unemployed, lives in a co-op, grows a small kitchen garden, and barters food with friends and neighbours for a more balanced meal. He continues to take free adult education courses, prep for and write the Canadian exams, and apply to CaRMS. He still has his goal to regain his Ob/Gyn specialty and practise medicine in Canada, but he is worried. He depleted his savings. He does not have a family here. He cannot return home and he does not have a savings or pension for old age. He feels his life is wasted in Canada.

Participant 11: Dr. Arju

Dr. Arju is a 35 to 39-year-old male general practitioner and program coordinator from East Africa. He completed a four-year pre-med program and a four-year Doctor of Medicine degree in the Philippines because there were no medical schools in his country. He graduated in June 2000. He lived and studied in different countries in Africa and Asia, and in America, and is now in Canada. He speaks several languages fluently, including English, and adapted very well to the North American lifestyle. He said he sees himself as an international citizen since he lived in different countries from a young age, primarily for the purposes of education. He is also interested in administration, leadership, and scientific research from his background as program coordinator, researcher, and writer. He is open to securing a medical license to practice family medicine in Canada, but has explored different career paths for other options since arriving. As an alternate career path and as a way to continue to use his medical knowledge and education, he applied for a master’s degree in Public Health and Epidemiology, but has not been successful. He is currently unemployed, enrolled in a government-assisted skills development program, works in non-professional jobs, and has been doing some observerships with a community family doctor in the west end of the city. He lives with his brother in his basement in exchange for assisting with his brother’s children.
Participant 12: Dr. Eddie

Dr. Eddie was born in South Africa and is the fourth of eight children. His father worked as an engineer, while his mother stayed home to care for the children. At 17, he was accepted at the highly selective Medical School in Europe and was one of four visible minorities in his cohort. He learned the local language, worked part-time to support his international tuition fees, and learned to survive as a foreigner with few financial or other resources. Through this experience, he gained the courage and coping skills that help him today as he endures his challenges in Canada. He completed a seven-year Doctor of Medicine degree in Italy in 1998. He is a general practitioner between the ages of 40 and 44 and practised family medicine for six and a half years prior to arriving in Canada.

Dr. Eddie met his wife, a licensed employed nurse practitioner, in the US. They immigrated to Canada because they felt it would be a better country to raise their three young children and continue their professional careers. Neither he nor his wife has been able to secure licenses to practice their profession in Canada. They decided she will return to her job in her home country while he stays in Canada with the children to try to obtain his medical license. The strain of separation has been difficult for them financially and emotionally. The children want to know why mommy doesn’t stay at home with them. Dr. Eddie is a single parent raising three daughters under great financial burden. He calls his daughters his greatest achievement. He does not mind coming home from work at 11:30 at night, preparing lunches and dinners for them, and waking up at 7:00 or earlier to get the two older ones ready for school. Although he has a babysitter for the children while he works his 3:00 pm shift at a car sales shop, he still must take care of the housecleaning, laundry, cooking and other household chores. The physical strain of being on his feet and often lifting heavy items at work, sweeping the floor, and greasing car wheels makes him want to obtain his license even more.

Participant 13: Dr. Kripp

Dr. Kripp was a trauma surgeon in his home country in Africa before immigrating to Canada in 2004. He was about 50 years old at the time of the interview. He completed a five-year Doctor of Medicine degree in 1984. He pursued postgraduate residency training in surgery and trauma in his home city and had practised medicine for 15 years before immigrating to Canada with his family. He was also a university professor in surgery back home. He has four
children of high school and university age. His wife was a healthcare professional back home and is currently working as a personal care worker in Toronto. He completed the MCC exams back home and received very high grades. He was told that he would have no problem getting a medical license in Canada. He passed the additional Canadian exams and was accepted by CaRMS. He was granted an interview, but not selected for retraining. He completed several observerships in Toronto, Stouffville, and as far away as Ottawa to gain Canadian experience. He worked in several different temporary jobs, with the most recent in insurance medicine, an area he is interested in pursuing. He has made several trips back to his home hospital and university to work for two–three month periods to maintain his clinical and teaching skills to remain competitive in Canada. During our interview, he said he was tired—too tired to keep travelling back and forth. He misses the stimulation and excitement of medicine and is very sad to have his career ruined. He contemplates returning home, but cannot leave his family here alone. He takes correspondence courses on insurance medicine and hopes to get a job in that area. He will try one more time with CaRMS this year and then decide what to do. He feels like a “victim” in Canada.

Participant 14: Dr. Tunde

Dr. Tunde, age 40–45, arrived in Canada in August of 2012. She graduated in 1997 with a six-year Doctor of Medicine degree from her home country in Africa. She did a subspecialist training in family medicine and practised clinical medicine as a family doctor for eight years on a full-time basis. She completed a master’s in public health while practising medicine and worked with the Ministry of Health for two years before immigrating to Canada with her husband, who is an accountant, and their two young children. She wrote the MCC exam back home and scored very high. Her application was accepted by CaRMS in time for the 2012 year, but she was not offered an interview. She plans to reapply next year. In the meantime, she was enrolled with the Ontario International Medical Graduate School for both the OSCE course and the written exams, at a cost of $1,850 per session plus taxes. She is also applying for the Master of Health Science and Epidemiology programs at U of T. She is hopeful that she will be successful next year in receiving her license to practice medicine in Canada. Currently, she is a full-time mother and homemaker while she studies for her exams and prepares for the tests.
Participant 15: Dr. Menita

Dr. Menita is a 40 to 44-year-old general surgeon from the Middle East who immigrated to Canada in 2001. She is married with one child. She completed her MD training and pursued a five-year postgraduate training program. She practised plastic surgery with cancer patients for three years in her home country before immigrating to Canada. She did not seek employment after immigrating. Instead, she focused on preparing for a license to continue her medical career. After eight years of studying and passing all the required exams and being accepted into the CEHPEA Practice Ready Assessment Program, the program was suspended. She continued her application with CaRMS for a residency program, but was not granted an interview. She was Vice President (Media) for AIPS0. In this position, she took up her concern and plea with the CPSO and the media to consider a restricted license for foreign doctors to practice medicine in Canada, but made no progress. She accepted a position as a surgical assistant in Western Canada, a position she said she was not planning to apply for, but circulated the advertisement to all her colleagues and encouraged them to apply. She took up the position, packed her things, and moved with her husband and child. She hopes that she will have further opportunities to work in medicine in Canada.

Conclusion

This chapter provides an overview of the research design of this study. It discusses the rationale for using a qualitative research methodology and a grounded theory approach. It explains the pilot testing, the recruitment of the participants, the consolidation of the research questions, and the conducting of semi-structured face-to-face interviews. It also provides narrative profiles of each of the participants, and addresses questions of validity. The overall purpose and aim of the study, given that “all lives matter,” was to understand the experiences of immigrant medical doctors in Canada and turn these experiences into opportunities for IMDs and their families. Despite the limitations in this study, I believe that possibilities for change to resolve the problem visible minority IMDs experience, is possible with Lewin’s (1946) action research, and Anderson’s (2005) and Weiss’ (1995) theories of change models. See Chapter 10 for further discussion on recommendations for change.
Chapter 6

Results Part One: Motivation

This chapter is the first of three chapters presenting the results of this study. It describes the findings relating to the first research question on what motivates IMDs to immigrate to Canada and what keeps them motivated after their arrival. The analysis shows that IMDs immigrate to Canada as financially self-sufficient immigrants, highly driven to settle quickly in their new homeland, achieve medical recertification, and continue their career as medical doctors. The participants describe how they came to Canada well prepared to engage in new opportunities for themselves and their families as promised by the government of Canada and how motivated they are to hold on to their professional career and identity. Chapter 7 (Part Two) takes a more global and economic standpoint on the findings. It looks at how Ontario could benefit if more IMDs gain access to jobs in the medical workplaces, and in return, contribute to their personal well-being and the province’s economy. Chapter 8 (Part Three) presents the impacts on IMDs’ lives when they are qualified for retraining but denied a position even though the government claims there is a shortage of doctors and they meet the requirements for retraining. Finally, Chapter 9 presents an action plan for change with a blueprint for a Diversity in Medicine program while Chapter 10 answers to the last research question on recommendations to improve the situation for IMDs.

The major finding in terms of motivation is that IMDs, although from developing and poor countries, were esteemed and respected professionals before coming to Canada. They had reached a level of “self-actualization,” coined by Kurt Goldstein in 1939, as referring to people with "a desire for self-fulfillment, namely with the tendency to become actualized in what they are potentially; a desire to become everything that one is capable of becoming” (Maslow, 1954, p. 22), before arriving in Canada. IMDs immigrate to Canada as qualified doctors with the motivation to continue life at a greater level of self-actualization than what they left behind. As Neher (1991) argues, this self-actualization is a continuing process.

Maslow’s Theory of Needs

Abraham Maslow, an American psychologist, became best known for creating the hierarchy of needs theory suggesting that from birth, human beings have three basic needs: physiological, safety, and love/belonging. Human beings must meet these basic needs one at a
time, before being motivated to move up the ladder to experience self-esteem and then self-actualization (see Figure 8). Maslow’s first three basic needs (physiological, safety and love) are necessary to maintain a constant normal state (Maslow, 1954). Without the basic needs being met, “all other needs may become simply non-existent or be pushed into the background” (Maslow, 1954, p. 384). As Maslow argues, if a person is hungry, does not have a safe place to live or cannot feel a sense of belonging, that person will not be motivated to write poetry or desire new shoes or a car. These things become of secondary importance if they are hungry. They will think of food before thinking of luxury, and utopia in this case “can be defined simply as a place where there is plenty of food” (pp. 385-386). If their basic needs are not met, if the person is sick, unemployed, old, has a disability and cannot work, or if the person moves away from loved ones and has no family or place to call home, their confidence level can drop. Achievement can be poor, motivation low, and reaching the next level of self-actualization may never occur (pp. 18-19 and pp. 385-386).

Maslow’s motivational theory and hierarchy of needs has gained popularity since the 1940s. The theory allows for people to evaluate their own lives to see how well they conform to Maslow’s ideas concerning the “good life” (Neher, 1991, p. 90). The theory, although became popular, has not been tested empirically. Despite this, and Maslow being outside the mainstream of testing and critical evaluation (Neher, 1991), the theory has been frequently adopted in organizations and in management and behavioural psychology literature.

I used Maslow’s work to theorize IMDs’ lives after they immigrate to Canada and are denied a retraining residency position to proceed to medical recertification for a license to practice medicine in Canada. Maslow argues that people tend to direct their actions toward achieving set goals (1943) by first trying to meet their basic physiological needs, then moving up the hierarchal ladder to self-esteem, and finally reaching the highest peak of self-actualization (Figure 8). According to Maslow (1943), motivational theory helps in understanding how people become motivated to achieve a need in their life.
Figure 8. Maslow’s hierarchy of needs.

Source: Wikipedia (2016, Figure 1).

The 15 IMDs who participated in this study expressed variations in their motivational drive. The majority felt proud of their achievements before arriving in Canada. They felt proud and satisfied with their status as a doctor and the recognition gained in society and in their professional workplaces. They felt confident and respected. They brought their families, belongings, and finances to help them settle quickly and be prepared to seek out continuation of their medical career. During the interviews, several participants said they had used up a good portion of their financial resources to pay for the Canadian exams and interviews for a retraining position, the CaRMS applications, and other tests. They said that, initially, they did not begrudge these expenses as they were part of preparing to practice medicine in Canada, but years later and finances mostly depleted, chances for a license are bleak.

Thoughts of having their professional status and career severed away from them and succumbing to underemployed and non-medical jobs were not what they expected to happen. Facing these have caused great embarrassments to IMDs. Some felt demoralized, humiliated, and fearful of their future and their children’s future. However, these debilitating experiences made the IMDs in this study even more determined to overcome obstacles. They use their every skill to work with family, collaborate, multi-task, and be persistent and frugal while networking,
forming study and support groups, and maintaining connection with the medical profession. Comparing the IMDs’ experiences with Maslow’s hierarchy of needs, I found that some of the participants, while lacking professional jobs, income and any kind of luxuries, did not wait until their basic needs were met to become motivated to reach their self-actualized goal of medical recertification. Rather, they arrived in Canada and moved forward with great enthusiasm and family cooperation with the aim to reach their goal.

There are also the IMDs who have already given up and succumbed to termination of their life-long career, dream, identity and professional status for various reasons and end up working in low-wage underemployed jobs. These IMDs may likely fall into Maslow’s description of hierarchy of needs with the aim to try and meet their basic physiological needs, depending on their financial and social circumstances. Others who have spent their life savings and lost all confidence and hope for a job in the medical field and do not have permanent professional jobs despite their high qualifications levels, are practically living in the poverty level. They tend to fall into Maslow’s hierarchy as they try to meet their basic physiological needs before thinking of reaching the self-esteem or self-actualization level of Maslow’s pyramid (Figure 8). IMDs who self-select for this study, however, are more determined to achieve their goal. They are refusing to succumb to economic plight. They believe strongly in their value and worth as medical doctors. Although hardships set in after years of application attempts for re-licensure, these IMD participants find ways to stay motivated and self-sufficient as described in Figure 9.

From my interpretation of the data, IMDs’ behaviour, explanation and description of their experiences as immigrants seeking to become medical doctors, I hypothesize that IMDs who persist in seeking medical recertification after being denied, believed that they can be successful and capable doctors. They believed they can regain their level of professional and self-actualized life they had back home. They place their goal of achieving medical recertification at the centre of their survival. All other needs as described by Maslow (physiological, safety and love) stem from the goal of achieving medical recertification. I surmise, therefore, that these IMDs fall within a ‘circular’ motivational model with their self-actualized goal as central to their being and all other needs project from that central point, as depicted in Figure 9 and compared to Maslow’s hierarchy of needs pyramid (Figure 8).
Figure 9. Circular motivational model.

Circular Motivational Model

The interviews revealed that the study participants were very clear about their goal of medical recertification. They were clear that this goal is the focus for themselves and their families and that everything else in their lives extends from their goal. Even if participants must work two or three part-time jobs, sacrifice family, social and community lifestyle and live on a meagre budget, their focus to achieve their long-term life-time goal of medical recertification is worth the sacrifice.

In the following interview excerpts, the IMDs in this study describe aspects of self-actualization they had reached before coming to Canada. On immigrating, they arrive with feelings of pride and self-worth, and the desire to become more of what one idiosyncratically is, to become everything that one feels capable of becoming (Goldstein, as cited in Maslow, 1954).

Dr. Arju: I was motivated to immigrate to Canada for the opportunity to enhance my professional career and for political reasons. There were no medical schools in my country in Africa where I could get a better medical education. I returned home to practice medicine after completing my medical training abroad, but I always wanted to go
to America to study and experience Western medicine and education in the English language.

Dr. Vera: I chose to immigrate to Canada because I thought I would have better opportunities to fulfill my craving and excitement to learn more about medicine and how to practice medicine in a more advanced and educated country. […] I heard about Canada is a beautiful country with lots of opportunities… Canada accepts immigrants from all countries and needs both doctors and immigrants. I decided to apply to come here. My application was accepted with no problem. […] Before I immigrated to Canada, I worked as an emergency doctor for almost five years and as a family doctor in a rural community. […] I want to be a good doctor in Canada and give back to Canada.

Dr. Gerty: Before I immigrated to Canada, I pursued an online Master’s of Public Health degree with the London School of Economics […] I had a house, and a car. Because I was working and my husband was also a professional, our lifestyle was pretty high level. I had a nanny for the children, people working in the home. I was Chief of Staff at my hospital. […] I was excited to continue my life in Canada with a new beginning.

Dr. Flora: I lived a “high” life. The respect was there for professional class people like us. I had three helpers—one for cooking, one for washing, and one to only take care of my daughter. I had my own driver who I just called when I want to go anywhere. I had a big house. Every year we go on a holiday to Singapore, Malaysia or Australia. The real problem in Bangladesh is really the security problem and air pollution. Doctors there, especially Ob/Gyn, Paediatrics, Radiologist, earn very good money, sometimes even better than here.

Dr. TFox is another participant who left a good job back home and immigrated to Canada with a career goal and self-actualization as central to his life:

I was an obstetrician back home for more than 10 years. I was single and in my 40s when I came to Canada. […] The main reason I decided to move to Canada was because I felt that I was capable to do more. I wanted to learn new knowledge, new advances in medicine, seek more opportunities in my profession… I heard that Canada also needs medical doctors. […] It was this Western country experience [of Terry Fox] about Canada that motivated me to want to one day immigrate to Canada. When I was younger and sick, the doctor told me I had to give up sports and cannot be an athlete because of my health. I will get worse. No one forced Terry Fox to stop training or insisted that his health would get worse if he didn’t stop. It was this Terry Fox story that inspired me to never give up.

These participants each had their own story about what motivated them to immigrate to Canada and what inspires them to keep reapplying for a retraining residency program. They articulated their satisfaction of being at the top in their profession and the excitement for the opportunities to continue their medical career in an advanced Western country as Canada.
Maslow (1954) claims that people become discontent and restlessness if they are not doing what suits them best. For example, musicians must make music, artists must paint, and poets must write if they are to be happy. In terms of achieving self-actualization, a person must be what he or she must be (Maslow, 1954). If this is the case for musicians, artists or poets, is it different for IMDs who are trained and educated professionals seeking better opportunities to excel in their professional field? I saw these participants as people who are passionate about their education and career. The desperate shortage of doctors in Ontario and across Canada further fuels their humanism and compassion for patients, and forges their persistence to regain medical recertification. As Dr. Artmad said, “patients need me. I am the doctor. I can’t give up.”

IMDs are not waiting to satisfy their personal and basic needs as depicted in Maslow hierarchy of needs (Figure 8) before embarking on their career goal to be what they must be. Rather, as depicted in Figure 9, some IMDs put profession and career goal at the center of their lives. All other family, personal and human needs extend from the central self-actualized point of medical recertification. The data show that most participants reached self-actualization prior to immigrating to Canada. They come to Canada well prepared to study, fund their exam preparation for medical recertification and sustain their settlement. Some IMDs pursued the MCC exams in their home country before arriving in Canada to save time and facilitate the recertification process. They forge ahead in a circular fashion in which they are driven, not by fulfilling basic needs as Maslow discusses, but by holding on to their self-actualized life as a physician who must care for his patients and family, just as a musician must make music or an artist must paint (Maslow, 1954).

IMDs tend to plan their lives around feeling and knowing that they are qualified, experienced and good doctors who have been successful in their medical career and have enjoyed good family and social lifestyles. They approach medical recertification with great confidence that they can pass the Canadian medical exams and pursue the necessary upgrade skills they would need to practice medicine in Canada. They come ready and willing to work, make sacrifices, relocate if they must, in order to reach their potential. Their motivational drive helps them maintain the demeanor of a self-actualized personality who has been successful, reached full potential, gained recognition and contribute to their profession and to Canada as future citizens.
Criticisms of Self-Actualization

One description of self-actualization by Maslow (1943) is at the point at which individuals reach a state of harmony in their life because they are engaged in achieving their full potential. They focus on their success and their self-image. This is the highest peak in a person’s life (Figure 8). Maslow (1954) also argues that cultural backgrounds and other factors such as the Puritan religion, which stresses work and struggle, striving, soberness, and earnestness (p. 62) can influence how some people reach self-actualization. Neher (1991) critiques Maslow for promoting the idea that people can only become what their native potential allows them to become and “nothing else” (p. 96).

Racial Biases of Self-Actualization (Maslow)

Neher (1991) and others point out Maslow’s theorization of self-actualization can be called into question on empirical grounds of racism because many of his claims appear racist. For example, Maslow argued that Blacks would have trouble rising over slavery because they did not have the same stages of development as White people have. Even though he made this claim in the 1940s-1970s when racism was rampant, I agree with Neher and therefore, cannot entertain Maslow’s claim of Blacks.

Molefe Asante commented at the Oral Exam (December 8, 2016) on the slave uprising in Haiti and elsewhere in the world, in relation to Maslow’s argument that Blacks would have trouble rising over slavery because they do not have the same stages of development (December 8, 2016). Asante commented that people may become suppressed when faced with suppressive conditions beyond their control, but he argues that they can understand the circumstances they were in and the context of time and act as necessary. Olson further referred to Genovese’s classic Roll Jordan Roll: The World the Slaves Made (1976) and how oppressed slaves used strategies of alteration, adaptation, accommodation, resistance, and rebellion in response to slavery.

Heeding the above, Maslow’s claim helps me explain a theoretical conclusion in my thesis arising from the complex circumstances of IMDs. Assuming IMDs have reached self-actualization before arriving in Canada, as evidenced by bringing their life savings and households with them on immigrating, two things result: First, they will be motivated to achieve their goals and therefore not follow Maslow’s model of hierarchal needs to become motivated to reach self-actualization. Second, they will fit better in a circular model of motivation where they
shuffle their lives around circumstances to meet their life’s needs while maintaining a sense of self-actualization, as has become clear in this study.

**Needs and Goals**

There is much discussion also on how needs might have different meaning. Neher (1991) argues that there is no consensus on defining a need or motive, or a common conceptual understanding of how goals, motives, and needs are different from one another. Rather, he asserts that needs are different from motives. Needs can be an inherent psychological desire that requires taking action for optimal functioning of self, as well as well-being. Needs can be a desire for control or a wish for closure. Motives on the other hand, might be based on dispositions and can steer a person in a certain way to do things (Elliot, in Neher, 1991). Therefore, as suggest by Beer and Huizinga (in Wahba & Bridwell, 1976), Maslow’s categories of need can overlap and not necessarily split into separate factors. Either way, as Wahba and Bridwell (1976) point out, over time it became a “tradition for writers to point out the discrepancy between the popularity of [Maslow’s] theory and the lack of clear and consistent empirical evidence to support it” (p. 212).

After analyzing my data and the above critiques, I maintain that IMDs’ motivations are driven to maintain self-actualization and reach a goal, that this drive becomes the central force in their lives, compared to Maslow’s theory that suggests basic needs in a hierarchal model is the central focus. Latham (2007) criticizes Maslow’s theory, but came back and agreed with Maslow, at least partially, that “people value what they need” (p. 261). It is the “value” that provides the principal basis of a person’s goal and goals are “similar to needs” (p. 149). They both have the capacity to “arouse, direct and sustain behavior” while value serves as a guiding principle of life (p. 149). Goals are the “situationally specific form of one’s values” (p. 176). Hence, taking Latham’s theorization, the goal can be referred to as a specific form of “core value” for an IMD. This goal also has the capacity to sustain need and behaviour. Pulling these together with IMDs goal as their self-actualized core value and the meeting their other needs extends from the central core value, my circular motivational model (Figure 9) better reflects IMDs’ motivation as already self-actualized doctors seeking to achieve medical recertification.

IMDs are educated and respected doctors with high education and top-level jobs. While they immigrate to Canada with the goal to use their skills, talents, interests, and passion to
become everything they are capable of becoming (Hagerty, 1999), putting that goal (Latham, 2007) at the center of their striving for success is also a good way to maintain confidence in themselves. This circulatory motivational model puts the IMD’s self-actualized goal central to all decisions and actions in their lives. Indeed, age may also be a factor in self-actualization and motivation in IMDs. For example, a younger IMD in his 30’s will not have the same level of self-actualization as an IMD in his 40’s or 50’s with many years of work and life experience. This does not, however, necessarily mean that the younger IMD is far from reaching self-actualization. According to the IMD participants in this study who ranged from 35 to 50+ years old with postsecondary education and work and life experience, they feel confident in tackling challenges to reach their goal. They feel resilient and competent to juggle their lives and work hard to achieve their goal said Dr. Eddie, while Dr. Artmad made the following comment:

The Canadian evaluating exams are expected to evaluate IMGs as par to Canadians. I studied hard and I passed these exams, and I have so many years of training and experience. I am willing to take the additional training needed, because I know that Canadian medicine is different from medicine in other countries. Why is it that the government or the medical profession does not want to accept me?

I agree that the education system and medical training here is good, but ours is very good too. I am not saying that all IMDs are good, but IMDs from good medical schools and good medical etiquette and experience do bring some experience that new Canadian medical graduates lack.

Dr. Flora, who practiced obstetrics and gynaecology for seven years before immigrating to Canada, has not given up her goal for medical recertification. She said she was an excellent Ob/Gyn back home. She held several high positions in Administration. She knows that she can be a good doctor here in Canada, especially for women in her community. She said:

I cook my own food for my family and it is cheap and better. We do not go out and eat. As long as my family is taken care of, I will spend every moment I have to learn and understand the Canadian culture and the medical profession, and prepare myself to be the best candidate for the retraining program.

This is my third time with CaRMS and, between preparing for the exams and taking medical courses at the IMD School, I am sure that one day they will choose me. I will not give up unless someone in the profession tells me I do not have a chance and I am wasting my time.

In 2005, Dr. Abdul Bashir, a doctor from Sudan, appeared in a TV documentary in Ontario in which he described his life as an IMD seeking medical recertification (Connexions,
n.d.). After spending his life savings on preparing and applying for a residency position in Canada, he slept on street benches, ate cheap food, worked in minimum wage jobs as a dishwasher, and saved his earnings to pay for future exams and residency applications. He did not wait until he could earn enough income to afford an apartment where he could be safer and look after his basic needs. His self-actualized goal as a medical doctor sustained him. After nine years of trying he was offered a residency program at McMaster University. A few years later into residency, he was already involved in helping his home country in the medical field (Hamilton Spectator, 2007).

Participant, Dr. TFox, also has infrequent minimum-wage jobs. He grows a small vegetable garden in his co-op in Toronto. He barters his food with friends at the co-op to have a balanced diet and stay healthy so he can continue to work and study for the medical exams and remain competitive for a retraining residency position. He needs acceptance, friendship, love, and affection like other human beings, but reverse self-esteem (Maslow, 1954) works for him. He wants the pride and confidence of being a professional doctor and said that he will not sit and wait for the satisfaction of comfort in other areas of his life. His will continue to keep his needs at bay while his self-actualized goal remains central.

Maslow (cited in Wahba & Bridwell, 1976) argues that if people’s basic needs are not met, they will not be motivated to satisfy the next needs in the motivational pyramid. However, as Wahba and Bridwell (1976) point out, Maslow’s theory misses the traditional issues of motivation that could be affecting people’s behaviour, such as how people view work, learning, and the environment of human action. For IMDs who have children, their children are a priority. Yet they learn to juggle professional and family commitments and, as Dr. Eddie said, he learned to become “resilient” in order to manage. In his case as a single parent with three daughters, achieving his goal of medical recertification is his ultimate priority, for his daughters’ sake.

IMDs learn to become creative, spontaneous, good problem-solvers, and multi-taskers to cope with adjusting to life in a new country. This entails even the little things like figuring out the bus system, the grocery store, the banks, the hospitals, and the university offices. Dr. Eddie and other IMDs with families need to find schools for their children and how to pick them up from school. They become excellent planners and organizers. Dr. Eddie gets his daughters ready for bed at night and for school in the morning, prepares their clothes for school, and combs their
hair. I asked if he combs their hair every morning. He “gleefully” replied like a proud parent, “yes, I braid them too.” When I asked other participants what motivated them to immigrate to Canada, Dr. Gerty said:

My daughter was eight and we want to provide her with an educational system that would not put her in a situation which I am in right now… I want her to have an internationally recognized qualification no matter what she ends up doing […] education and family.

Dr. Tila said: I immigrated here for a brighter future for myself and my kids—to live in a more peaceful, democratic and westernized country where there are more opportunities for my children. It is a safer country for kids. There is a shortage of doctors in this country. I thought it would not be difficult to get a license to continue to practice medicine here in this country.

Dr. Artmad said: It is a better country with opportunities and a shortage of doctors. I came here, safety and security are great. It feels safe to be here, but since I came here for the past seven years, I have juggled things around to write the Canadian exams to the point that I gave up time with my wife and children to make sure I study and was ready for the exams.

Dr. Enzo replied: I wanted to go somewhere where there were opportunities to grow and be a good doctor […] always looking for something else to improve my skills. Knowledge can be gained from books but not skills. There are more opportunities in this country.

Dr. Enzo continued:

Trying to become recertified here is like having the adrenalin flow through the veins in your body so fast it makes you numb to all adversaries…and all you want to do is just keep going and prove that you can do it. […] A friend of mine who immigrated to Canada in 2001 got accepted in 2011—ten years later. If he can do it, I can do it, and I will keep going.

There are no distinct marks or reasons telling you cannot cross over to the good side…you keep going. It is like an addiction for some of us IMDs. It is a chance you take and that is the motivation…not feeling sorry for yourself. Either that or admit your failure and work for nothing for the rest of your life and lose everything you have worked and earned in your whole life.

Some participants such as Dr. Kripp said that the system is not being honest with IMDs. While he is very discouraged after spending so many years with no guidance or direct help, he cannot give up his goal for a medical license and lose his professional identity. Therefore, like other IMDs, he seeks to become re-energized and keep up the routine of rewriting the exams and resubmitting CaRMS applications. So, while the reasons why IMDs come to Canada includes
family, children and other personal reasons, becoming recertified to practice medicine or work in the medical field is paramount for IMDs. This is a mark of professionalism, success, family pride and self-actualization for IMDs.

My observation is that IMDs outwardly project a confident, proud, and professional demeanour, but underneath they are suffering, especially if they are in their fourth, fifth, and more attempts seeking recertification. However, there is still a strong motivation to achieve their goal. Dr. Artmad explained his frustration:

The medical profession and the government should be more honest with immigrants and not play games with their lives and their families’ lives. Presently, the pathway to medical recertification for IMDs is not very helpful as IMDs are just turned back with no explanations as to why. How can they prepare? They could end up trying to improve themselves year after year and have no way of knowing if they can fit in the expectations that the profession is looking for because they do not tell exactly what they want. Other provinces, such as Manitoba, take a different approach than Ontario.

The lack of information and feeling discouraged by the system does not stop IMDs from persisting and keeping their eye on a career in medicine. As Dr. Artmad said:

I came to Canada to live in a more peaceful, democratic and westernized country where there are more opportunities for my children. It is a safe country for kids, especially Muslim families. Then, because there is a shortage of doctors in Canada, I thought it would not be difficult to get a license to continue my practice of medicine in this country. But that has not happened yet and I am not removing my eyes from the gaze.

Taking time to settle in Canada with their families and being comfortable at home before preparing for the competition for residency programs is not a common tendency among IMDs. My findings show that IMDs generally start to organize themselves to prepare and seek medical re-licensure as soon as they arrive in Canada. I observed the same when I worked at the medical school. As I mentioned, IMDs would come to my office straight from the airport or soon after arrival. Cold wintry days did not deter their motivation to seek out their goal. One IMD arrived at my office on a cold January morning by taxi. She brought her two little children wrapped in blankets, still in pyjamas. She explained that she wanted to meet me before going to the shops to buy clothes and winter coats for her children.

IMDs are older in age. The majority come with families and other dependents. Having brought their belongings and life savings to Canada, they need a home and a car. They need to work and save money for their children’s education and for their own retirement which they
cannot do on salaries as security guards (Dr. Artmad) or coffee servers (Dr. Seena). However, years later after they exhaust the funds they bring to Canada for medical recertification and exams, and depriving themselves of investing in a home or sending their children to private schools, they rely on their meagre income to keep up with the application process. IMDs are forced to act quickly to overcome the odds and forced to use their instincts for survival, which Maslow’s theory does not quite deal with in terms of human behaviour (Wahba & Bridwell, 1976). Dr. Stella said that her motivation comes from fear of being stuck with unskilled, low-paid work and having to give up her professional career. She fears losing her power and prestige as a doctor, and the pride she had in the medical profession. The idea that she will never be able to practice medicine again is terrifying and motivates her to make sacrifices and be content as she looks at the bigger picture. Dr. Seena also expressed her motivation to reach self-actualization:

I was a very good doctor back home. I practiced medicine for 10 years. To avoid [never being able to practice medicine again], we have to push ourselves to not give up…this is what keeps me going, not food or love. Focus is on the goal.

A goal, as Neher (1991) argues, is something people might lack in the present and aspire to achieve in the future. Also, after achieving a goal, people “typically set new goals […] and the cycle repeats itself” (p. 103). This is not the same as aiming to meet a basic physiological need such as eating a meal. Maslow sees this as being motivated by deficiency or deprivation while Neher (1991) sees it as the individual who seeks greater freedom and choose to reach goals even if they are “practically unlimited in their scope” (p. 103). This shows the characteristics of higher-level motivation (Neher, 1991). This can also result in meeting a wider variety of lower-level needs (p. 103). What Neher and others such as Eisenberger (cited in Neher, 1991) believe is that an individual’s purposeful choice of challenges to reach a goal could lead to greater motivational satisfaction.

Dr. Maboo was still single when I interviewed him. He did not have a family to tie him down in Canada. He chose to return home after several years in Canada, and start life as a doctor all over again rather than face the humiliation of living in Canada where he worked as a shipper on the dock and was an alien doctor in distress. This is what he said:

The main reason I decided to move to Canada was because I felt that I was capable to do more, learn more and seek more opportunities […] I started the process of immigration
by the time I write the exams and they accepted me to immigrate to Canada, it took me almost four years. My reason didn’t change, but I wanted to experience it, that so I guess I was looking into job and what was happening in my country.

I put all things together and moved to Canada, and I hope that because of all the advertisement that there was a shortage of doctors. [...] I was hoping that by the time I left my country, I would get through the preliminary screening and criteria selection process, but the opportunity did not really happen.

After passing all the exams and exhausting the funds he brought to Canada to secure a license, he found the process “confusing and frustrating every year.”

They keep changing the requirement for eligibility. They keep coming up with new exams and tell us you need to pass another exam and another exam. This was like the time in the 1900s when the CPSO controlled licenses and the U of T wanted to make medical school a business, and U of T complained that CPSO changed the rules all the time. It was too much for anyone and I was single and had to make a decision, so I went back home.

Several participants said that if they had known the reality in Canada, they would not have immigrated to Canada. Some said they had opportunities to go to the US, but decided that since Canada has job shortage, they stayed. Others said, they would have come with different plans or gone to the UK, or a British colony where there might be better chances to maintain their self-respect, dignity, and confidence. Some said they felt “betrayed” by the government. To maintain their identity as professionals and having to maintain recency of training (HealthForce Ontario, 2016), they return home for a month at a time to work in their local hospital. This is very expensive for the IMD and difficult on the family. It is harder for the female physicians who must leave their children with spouse and relatives. One IMD said she was advised by a leader in a residency program in Ontario to take a three-month leave from her job and return home to update her clinical skills. First of all, she has a young daughter in school and could not leave her for three months. Second, she did not want to request a leave from work, for fear of losing her job upon return. Third, she will have no income while she is away and would have to use her savings for a flight back home. When she asked if there was guarantee for a residency position upon her return, the answer was simply “no.” She would have to compete with the other IMDs and CIMGs. Ironically, however, while foreign experience and clinical skills are under-valued in Canada, IMDs are advised to seek out clinical experience back home to remain competitive and within the recency of training timeline.
Another IMD, Dr. Menita, finally gave up after several attempts in Toronto and moved with her family to a province in western Canada for a Physician Assistant program. She came to Canada with two young children and her husband. She spent the first 14 months studying for the Canadian medical exams and writing the exams. She did not look for work. Their goal as a family was for her to take the time to get her Canadian medical requirements quickly so she could transition into a professional job. While she has not reached the poverty level in Canada because of her husband’s income, she is frustrated. She lives in fear of losing her identity as a medical doctor which she worked very hard to achieve in her home country, a country where educational opportunities are curtailed for girls and where those who receive higher education, especially in medicine, are very well respected. She is embarrassed to go to her child’s school as she would be asked too many questions about why she is not working as a doctor in Canada. This can be damaging for the child.

Dr. Gerty explained that she came to Canada with good financial resources and a Plan B to support herself and maintain her lifestyle. After settling in the country for a while, she intended to pursue re-licensure. She worked in a medical institution. After being around doctors and patients in her Plan B job in the medical field, she said her desire to work in medicine and care for patients kept coming back. “It was an automatic reaction,” she said. “All you think about is what you can do differently and you can go crazy thinking about it. She was Chief of Staff in her field and had several other leadership activities in her hospital and community. She said, she could not separate her emotions for wanting to work with patients. “In the end, you are stuck if nobody gives you a chance. […] The time goes by and you are a nobody in this country.” The vast difference in unemployment between university educated immigrants five years after arrival in comparison to Canadian-born graduates (Paperny 2014) is shown in Figure 10.
Figure 10. Unemployment rates—IMDs compared to Canadian-born graduates
Source: Paperny (2014, Figure 1)

This gap will only continue to grow as labouring jobs become scarcer with technological advances. If changes are not made soon to help qualified IMDs and redirect others to transitional jobs, more IMDs will end up permanently underemployed or unemployed.

Hierarchal versus Circular Motivational Model

I have taken a bold step in suggesting a new Circular Motivational Model as more reflective model to describe IMDs’ motivation and self-actualization as immigrant doctors seeking medical recertification and facing consistent barriers that impede their motivation to success. I feel justified in making this claim over accepting Maslow’s hierarchal motivational model for the following reasons.

First, the data from the 15 IMD participants, ranging from 14 different countries in the Middle East, Asia, Africa, South America, the West Indies and Eastern Europe with various specialty backgrounds and age range, reveals the excitement IMDs have in immigrating to Canada for professional, educational, and family betterment. They come as highly motivated professional doctors ready to start a new life and regaining their professional career and lifestyle is central in their focus. Achieving medical recertification becomes central to their lives. This focus is the core for meeting all their other needs. If they make sacrifices now, it will help them reach their goal. IMDs do not necessarily fit into Maslow’s hierarchy of needs, where food, shelter, family, and love are deemed as lesser needs. As seen so far, these needs do not take a lower stand in their lives. They are equal to their personal survival and their survival as a family.
Therefore, a circular model of motivation that gives equal pull to all of Maslow’s hierarchy of basic needs of individuals, with self-actualization at the centre of their lives rather than at the peak, seems more appropriate in this study. I, therefore, further believe that a circular motivational model (Figure 9) is more reflective of how IMDs are motivated to survive in Ontario. They do not sit and wait.

Second, there are many stories about IMDs’ deficiencies in their foreign credentials, language, medical skills and communication. There are stories about their underdeveloped-world medical experience, and that they should be thankful that Canada accepts them. IMDs are grateful because their children can have better schooling and other educational opportunities. They can become citizens. Some are content that if their medical identities are taken away, their children will have better chances becoming doctors and maintain the family status. However, looking at this from a patient-care need, by the time these children become doctors, they will likely not have the same level of language and cultural understanding as their parents (current IMDs) to benefit the growing need in Ontario’s diverse communities (Asanin & Wilson, 2008; Coloma et al, 2013), a need that can better be provided by doctors with similar international culture, language and interpretation skills (Guo, 2008, Gunaratnam, 2009; Esmail, 2016). It may be of better value to the patients and the IMDs if the government and the medical profession can heed the recommendations in this study to re-think how to capitalize on IMDs’ foreign skills to serve the patients and demystify some of the traditional stories told about IMDs?

**Conclusion**

Maslow’s theory of motivation is still highly influential in the literature today. I decided to use his theory to analyze and argue my findings on motivation. In the process, I concluded that a circular process of motivation better describes IMDs and the findings in this study. The circular model enables me to draw comparisons with supporters and critics of Maslow’s theory while reflecting on the lives of IMDs and their experiences.

Whether IMDs receive inaccurate or inadequate information on securing a residency position or whether they are denied a position for whatever reasons, the underlying theme is, IMDs come to Canada with good financial and other human capital that contains values to patients in Ontario. Mostly, IMDs come to Canada, motivated at the highest peak of life. They come to build a new life as professional doctors and live and contribute as citizens to the country.
As my data suggest, IMDs were at the level of self-esteem to self-actualization in Maslow’s five-step pyramid before arriving in Canada. Coupled with Wahab and Bridwell’s (1976) findings that reject Maslow’s proposition and others who have doubts about his theory, I suggest the circular motivational model is more representative to discuss IMDs’ motivation for coming to Canada and continuing to seek medical recertification even after being denied. It reflects IMDs and their families as motivated to regain professional status in the workplace and education levels in Ontario. It also shows the cohesiveness of IMDs and the importance of family unity and socialization.

It is important to move forward with more research on this model given that today’s society is continuing a rapid change as a result of technological advances and globalization (Coutinho et al., 2008), especially in terms of education, work, and workplaces. It is important to rethink new ways to assess IMDs in light of providing a needed service to patients while respecting IMDs and prevent continued discouragements that lead to human “broken-ness” and “broken-spirits.”
Chapter 7  
Results Part Two: Economic Quandaries Facing IMDs

This chapter focuses on the unexpected economic quandaries and challenges IMDs face after arrival in Canada. I start the discussion with principles of supply and demand in the context of the doctor shortage problem in Ontario and Canada. I argue for keeping the demand high towards maintaining professional standards and providing good patient care to patients but at the same time, avoid the shortage because of the life and death impacts on lives of patients. I then compare the costs of training one IMD and one Canadian doctor. I also compare IMDs to internationally trained dentists (ITDs) and address the economic losses that IMDs incur with no prospects for economic outcomes. I provide an example of how much income an IMD loses per year after immigrating to Canada. I show that 15 IMDs in this study lose an average of 7.67 years of prime work at professional-level salaries. This adds up to a significant loss of personal and disposable income, as well as contributions to the Ontario and Canadian economies.

Supply and Demand

Physicians and leaders of the medical profession have historically advocated for increased enrolment in medical schools to train home-grown doctors to meet the demand for doctors in Ontario and across Canada. Medical economists such as Mendelson (2010); Benarroch and Grant (2004); Evans (1976), calculated it was more economical to retrain immigrant doctors. Regardless of this assumption, Ontario medical schools continue to limit the retraining of IMDs while the shortage of doctors and medical services to patients remain high.

One Ontario patient, John Hill, recounting how he suffered from bouts of illness after transplant surgery said, “it’s been a serious up-and-down roller-coaster since 2010” (Jeffords, 2015, p. 1). Since receiving a kidney transplant he has had to go to the hospital emergency room because he does not have a family doctor. Rather, the hospital could not admit him due to the high level of germs in the hospital that could affect him as a transplant patient (p. 1). The news that the Ontario government has cut 50 residency positions has him worried. He is concerned that the low number of physicians will be detrimental to the 800,000 patients in the province who do not have access to family doctors (Jeffords, 2015; Leslie, 2015). Meantime, thousands of IMDs eligible for retraining programs and available to fill the need, and who will require less training than a Canadian graduate, are not considered part of the supply of doctors. It was embedded in
the CPSO (2004) recommendations that immigrant doctors be kept in the planning infrastructure to ensure appropriate physician supply in Ontario but IMDs are not selected to fill the shortage.

The process of supply and demand is key in economics. It has been attributed to Adam Smith in the 1770s in his observation of the changes that occurred in the manufacturing and production of goods (Smith, 1986). The economic principle that guides the theory of supply and demand is generally that if there is a low supply of a product and there is a demand for it, the price for the product increases (Smith, 1986), but if the demand for the product meets the supply, the price is expected to remain stable (Figure 11).

![Supply and demand diagram](image)

**Figure 11.** Supply and demand
Source: The Law of Supply and Demand (2014, Figure 1).

As alluded to earlier, the shortage of doctors has been looming in Canada for many years. In 2007, approximately 1.7 million Canadians aged 12 or older were unable to find a regular physician (Statistics Canada, 2008). A 2007 research poll found that 14% of Canadians (approximately five million) did not have access to a family doctor. More than 41% of this group (approximately two million) were unsuccessful in their attempts to find a family doctor (CFPC, 2007). Today, almost five million people in Canada do not have access to family doctors and other specialists and many ethnic patients do not have access to doctors who can identify with them, culturally and linguistically. This shortage is an assertion that supply of doctors is low and demand is high, thus forcing a scarcity of doctors. It means there is a need to produce more doctors and added costs will occur (Rajan & Lipsey, 2008, p. 4) to do so. As well, if the demand
exceeds supply, as the law of demand states, the price or value of the service would rise (Rajan & Lipsey, 2008), thus allowing for doctors to demands higher costs from the government for their services. Additionally, if demand is high, more doctors will be needed. This will effectively increase the government’s budget to train more doctors at the expense of the taxpayers’ dollars.

Examples are as follows: the cost to train a Canadian for a 5-year specialty program such as Ob/Gyn, surgery or paediatrics, is $780,000 (Lysyk, 2013). This is after cost for a four-year undergraduate university degree and a four-year doctor of medicine degree. The cost for salary for a five-year residency training in Ob/Gyn adds up to $334,322.01 (PGY1-PGY5 PARO salary), while the cost of salary to train a family doctor in a two-year residency adds up to $117,972.51 (Table 9), as calculated from the PARO Annualized Salary Scale for medical residents in training in Ontario universities (PARO, 2015). Of the 15 IMD participants in this study who have met the qualifications for retraining residency (and there are several thousands more in Ontario alone), nine fit within the 5-year specialist programs in Ob/Gyn, general medicine, general surgery, orthopaedic surgery, and emergency medicine. The remaining six fit in the 2-year family medicine specialty. There are also other administrative costs for training doctors that are not accounted for. Despite to say, these figures show a vast difference between training an IMD and the cost for training a Canadian doctor. This basic general non-analytical information is only a sample of difference in training costs of an IMD and a CMG, and the cost to the Canadian governments and the taxpayers.
### Table 9

**Professional Association of Residents of Ontario (PARO) Annualized Salary Scale for Medical Residents in Training in Ontario, 2015**

<table>
<thead>
<tr>
<th>Position / Classification</th>
<th>Effective July 1, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>PGY1 Resident</td>
<td>$55,825.76</td>
</tr>
<tr>
<td>PGY2 Resident</td>
<td>$62,146.75</td>
</tr>
<tr>
<td>PGY3 Resident</td>
<td>$67,139.98</td>
</tr>
<tr>
<td>PGY4 Resident</td>
<td>$71,604.26</td>
</tr>
<tr>
<td>PGY5 Resident</td>
<td>$77,605.26</td>
</tr>
<tr>
<td>Total for PGY 1-5 residency</td>
<td>$334,322.01</td>
</tr>
<tr>
<td>Total for PGY 1-2 residency</td>
<td>$117,972.51</td>
</tr>
</tbody>
</table>

Source: Professional Association of Residents of Ontario (2015)

A medical student in Ontario universities is required to have a 4-year undergraduate education before pursuing a four-year doctor of medicine (MD) degree. They then proceed to a two-year family medicine or five-year specialty residency program for training to become a specialist in their fields. As per Lysyk, the cost is substantial to the government to train a doctor in Canada (Lysyk, 2013). A Canadian graduate spends a total of 10 years in post-secondary education to become a family medicine doctor and 13 years to become an Ob-Gyn or other medical specialties. IMD are already trained doctors. They should only require top-up training and education to bring them up to the Canadian standards. However, the profession determines that these IMDs accepted for retraining for an eventual license to practice medicine should re-do the full 2-year or 5-year residency program.

Historically, medical doctors in Canada fought to maintain a specific number of doctors to prevent over-supply. Over-supply in turn leads to reduced value of the doctors’ services if the supply is higher than demand. Doctors have historically advocated to protect the profession from outsiders. They sought to maintain the profession in its rooted British culture and model of medicine without expanding the diversity in the doctor population to reflect the diversity in the
patient population. This ends up causing the doctor-to-patient ratio, especially for ethnic patients, to remain low (Esmail, 2016). As per Esmail’s (2016) calculation, if Canada does not accept more foreign-trained physicians, and as the shortage continues, the price for doctors’ services will rise as in any functioning markets (p. 33). Esmail posits that in the Canadian health care marketplace, it is impossible to adjust supply and demand because of the restrictions on both the prices and supply of medical services. He suggests that the more obvious way to reduce the shortage is to remove restrictions on training, practice and pricing, and to introduce new user charges. This will “increase the supply of services of doctors to patients” (p. 40). Ironically, since Ontario no longer has an extra-billing system to absorb extra user fees, this is not an option for Ontarians.

In 2004, the CPSO recommended including immigrant doctors in the planning infrastructure to ensure appropriate physician supply in Ontario. In 2008, Esmail (2016) recommended removing restrictions and accepting more foreign-trained doctors. However, what we have seen to date, is a decrease of IMDs and an increase of CIMGs to the profession. Restricting IMDs to fill the doctor shortage has other impacts on the cost of healthcare as sick patients become sicker and as IMDs become stressed and more reliant on healthcare rather than gaining professional employment and contributing to the economy. There are also greater challenges looming as Canada accepts another quarter of a million newcomers, 25,000 refugees, other workers and students from developing countries who will choose to settle in Ontario and will eventually need medical care/attention. With this, the current low supply of doctors translates to a higher payment for doctors’ services as their value for services goes up. While this could be welcoming news for doctors and the Ontario and Canadian Medical Associations, it is not so good news for the governments’ treasury.

Over the decades, the consumers of medicine (the patients in Ontario) have become more diverse in the breadth of illnesses, health behaviours, communications and expectations in patient services. It is likely that this diversity will increase with the expected newcomer patients from all different backgrounds. The literature also shows that technological shifts, in addition to physician retirement, migration, and lifestyle changes with doctors choosing to work fewer hours (Esmail, 2016), will affect the demand for doctors. Taken together, these factors will increase the short supply of doctors, create higher demands, and further imbalances in the doctor-patient ratio for people of ethnic backgrounds, if the focus continues to produce home grown doctors.
In the “classical” economic period, the labour force was more homogeneous, non-technological, and employment was equated with the physical effort made by individuals in the workplace. Workers were considered substitutable for jobs if the demand was there (Livingstone, 2009). In the case of IMDs, the jobs are there because of the high shortage of doctors, but IMDs are not considered substitutable for the jobs. Rather, they are considered unsuitable (Zulla et al., 2008). The post-World War II economic expansion that led to the shortage of labor supply and introduction of new immigration laws to attract foreigners to work in Canada (Canada Immigration Visa, n.d.), opportunities for IMDs in the medical profession was restricted to underemployed jobs rather than retraining for professional job vacancies. What is interesting here is, research continues to target IMDs as lacking the language skills and understanding of how to do and get things done in the healthcare system (Hall et al., 2004). Instead, the efforts have been to increase medical school enrollments and appoint CIMGs to fill the vacancies. Nick Busing, representative of the Faculties of Medicine in Canada, made an appearance at the Standing Committee of Finance, Canadian House of Commons, and requested the need for government support to address the challenges [shortage of doctors] confronting the healthcare system (RCPSC, 2009, p. 5). Busing called for self-sufficiency of doctors through home-grown production of doctors. He requested converting 50 Visa trainee positions to CIMGs and IMDs positions (Parliament of Canada, 2009). Two years later, the 2011 statistics show that 47% of the IMG positions went to CIMGs and only 33% to IMDs (CAPER, 2011). In 2012, results show that 1,832 (38.5%) of CIMGs (born in Canada) passed the MCCEEs while 2,930 (61.5%) IMDs (immigrants born outside of Canada) passed the exams (Association of Faculties of Medicine of Canada, Data Point, 2012). These numbers are clear evidence that higher numbers of IMDs are denied access to re-licensure to practice medicine. They show that there is a continuing downward trend to reduce the number of IMDs’ entrance to the profession.

All Lives Matter

The Canadian governments provide funding for healthcare to all people of Canada regardless of socio-economic class. All lives are equal. All lives should matter, but still patients are left to endure illnesses and suffering in all parts of Ontario. Refugees arriving in Canada end up facing a foreign medical system that could be intimidating and very stressful. This would be
forgivable if there was a real shortage of doctors, but with thousands of qualified IMDs, is there a real shortage?

Canada has gained an international reputation as a country that needs, and will take immigrants and doctors. It attracts highly educated immigrants including doctors and should have the capacity to re-educate them and capitalize on their valuable skills and expertise to boost the country and the people. As shown in Figure 12, almost half (47%) of the Toronto population is made up of a diverse group of immigrants including South Asians, Chinese, Blacks, Filipinos, and Latin Americans (Canadian Institute for Health Information, 2015). Newcomers are encouraged to maintain their cultural identity, language, celebrations, and lifestyle but the profession focuses on gender equality and to a lesser extent on diversity with female to male physicians in Canada over diversity equality as fewer IMDs are selected to join the profession.

![Top Visible Minorities, Toronto CMA, 2011](image)

**Figure 12.** Top visible minorities in Toronto in 2011.

In 2015, Josh Tepper addressed the state of importance of accessible primary care for patients, as well as the value of family doctors as the “gatekeepers and cornerstone” of the health system (Tepper, 2015, Section 3, para. 3). However, it is not clear if IMDs are considered part of the pool of family doctors. The AFMC recognizes the need for a diverse group of physicians in the medical profession. A 2011 study which focused on the current issues facing IMGs (or IMDs
in this study) and the diversity in the Canadian patient population, was conducted with the need to cultivate IMGs successful integration in Canada (Association of Faculties of Medicine of Canada, 2012). It made the following recommendations:

1. IMGs require orientation to provide them with the knowledge, both overt and tacit, required to integrate into the clinical and educational environment, as well as support programs for them and their families.

2. There is great diversity in the IMGs who come to Canada, which requires in-depth assessment both for proper placement and to allow postgraduate programs to adapt to their training needs. Resources are needed to meet this great diversity of learning needs.

3. Teachers need training to meet the specific training needs of IMG residents (Association of Faculties of Medicine of Canada, 2011)

I called the AFMC office in September 2015 to ask about the progress on implementing these recommendations. I was told that they did not receive funding from the federal government to proceed. The bottom line is: There is recognition of the increasing diversity of patients in the GTA and throughout Ontario but there is less focus on capitalizing on IMDs’ skills to train doctors to deliver patient care to this diverse group of patients. The focus continues to aim on training home-grown Canadian doctors despite the heavier costs. Perhaps, cultural traits do not occupy space in medical academic curricula as argued by Yosso (2006), and this is one way of denying or limiting IMDs’ access to the profession, even if it promotes social inequality and a waste of taxpayers’ dollars.

The Poverty Phenomenon of IMDs

There is ample reporting and statistics showing “recent immigrants are more likely to live in poverty” (Statistics Canada, 2013). Many immigrants have children. Many speak languages other than English or French. As documented in the Statistics Canada 2013 Labor Force Survey, almost three-quarters (72%) of racialized persons, not including Aboriginal Natives, are living in poverty (Statistics Canada, 2013). Even though, as Challinor (2011) claims, the goal of the immigration system is to “encourage” highly-skilled immigration as a means to build human capital within Canada’s aging labor (para. 2), the majority of participants in this study have low-
paying, underemployed and labourer jobs unmatched to their skills and educational qualifications.

The 2012 Ontario Ministry of Finance Report shows an estimate in Table 10, that in 2010, Canadians earned $860.04 weekly or $44,722.08 in 52 weeks. Immigrants with five or less years in Canada earned on average $654.63 a week or $34,040.76 in 52 weeks. Immigrants with five and more years in Canada earned $841.06 or $43,735 in 52 weeks (Ontario Ministry of Finance, 2012). The earnings gap between university-educated immigrants and their Canadian-born counterparts is startling. For example, in 1995, the gap stood at $24,437 annually. By 2005, it had grown to $27,020 (Drummond & Fong, in Ontario Ministry of Finance, 2012). In 2009, almost one-quarter (23.8%) of immigrants who had been in Ontario for less than five years were in the low-income category. This figure is much higher than the overall low-income rate in Ontario of 13.1% (Labour-market Performance, Ontario Ministry of Finance, 2012).

Table 10
Average Weekly Earnings Lower for Landed Immigrants in Ontario: Labour Force Survey

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average total per week</td>
<td>$766.16</td>
<td>$784.58</td>
<td>$814.88</td>
<td>$830.86</td>
<td>$848.00</td>
</tr>
<tr>
<td>Average total per year</td>
<td>$39,840.32</td>
<td>$40,798.16</td>
<td>$42,373.46</td>
<td>$43,204.72</td>
<td>$44,096</td>
</tr>
<tr>
<td>Very recent immigrants,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 years or less per week</td>
<td>610.72</td>
<td>597.78</td>
<td>636.75</td>
<td>626.53</td>
<td>654.63</td>
</tr>
<tr>
<td>Recent immigrants,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5+ years / per week</td>
<td>782.77</td>
<td>808.92</td>
<td>822.42</td>
<td>828.47</td>
<td>841.06</td>
</tr>
<tr>
<td>Born in Canada per week</td>
<td>769.62</td>
<td>787.98</td>
<td>823.12</td>
<td>842.75</td>
<td>860.04</td>
</tr>
</tbody>
</table>

Source: Statistics Canada (2012, Table 10.3).

Working conditions for IMDs in underemployed jobs include long days, weekends, evenings, and night shifts. Dr. Artmad, for example, makes a salary in the range of $25,000–$30,000, the standard for security guards in Toronto (Security Guards Salary, 2015). This low income means he pays a smaller amount of taxes than if he were making a professional level salary, which in turn means an earning loss for him and a smaller tax contribution to the government. It should be noted that by this stage in the IMDs’ lives, they have already been in
Canada for a few years and most of them have almost depleted the financial resources they brought to Canada to cover the costs for medical recertification. Some are now starting to rely on their poverty level salaries to pay the costs of exams and the CaRMS application process. No financial assistance is provided by the government or the profession for courses to help them prepare for the exams. There are no sponsored or fee-paying courses offered by Ontario universities to assist IMDs with the skills and knowledge for re-licensure. IMDs save or borrow money to pay the exorbitant exam and application fees but are given no assurance of a retraining residency program. They are not given any kind of feedback, advice, or counselling about their exam performance or how to proceed. So, IMDs continue with the recertification process year after year.

One of the study participants, Dr. Artmad, who was Chief of Surgery in his home country and owned a medical clinic with a staff of 15 including his wife, explained how he came to work as a security guard:

I have to do it because there are no other jobs. I came to Canada and looked for many jobs while I was studying for the exams, just some job to tie me over and provide some extra cash to help with my family while I prepare for the license. I could not find any work. Luckily, I met this guy at the local library who was also a doctor, and he told me about how to register as a security guard. I did. Jobs are not easy to get but I needed some kind of work to tie me over and to help me pay for the exams. I was expecting to be licensed by now. They are expensive.

Several years later, Dr. Artmad is still working as a security guard, preparing and reapplying to CaRMS for a chance at a retraining residency position while still motivated to reach his self-actualized goal.

Costly Risk for a Chance at Recertification

IMDs wishing to compete for a recertification program in Canada are required to write several costly Canadian exams (Table 11). The exam fees change often. They do not include study materials. Compared to Dr. Artmad (above) who was a senior chief at his hospital and owned his medical clinics with 15 staff and now working as a security guard in the GTA, Dr. Enzo who is a more junior physician explained his situation as follows:

I took extra medical training at home to prepare myself to be competitive for work in medicine in Canada, but four years after I come to this country, I had not made much progress. I had to find work to pay the rent ($1,000/month), feed the family.
Professionally, it cost a lot of money to study for the exams. I worked several jobs to keep paying for the exams and to support my family. If you do not work here in Canada, you would not have any money. You cannot survive in Canada without money, but if you work, you cannot study, and it ends up costing more.

The exams are serious. They determine a person’s ability to engage in residency training equally with Canadian residents. When IMDs pass these exams, it reinforces their new Canadian knowledge and competence. It gives them the confidence, inspiration, and self-worth that they can practise alongside Canadian-trained doctors. Passing the exams, which are the same for Canadian-trained doctors, is a testament to the ability of IMDs to understand and work in medicine in Canada. Despite passing these exams, however, almost 90% of IMDs are not accepted for retraining.

**Table 11**  
*Costs and Fees for Medical Recertification*

<table>
<thead>
<tr>
<th>Exam Required for IMDs</th>
<th>Application Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Council of Canada Evaluating Exam (MCCEE)</td>
<td>$1695</td>
</tr>
<tr>
<td>Medical Council of Canada Qualifying Exam-Part 1 (MCCQE)</td>
<td>$950</td>
</tr>
<tr>
<td>Medical Council of Canada Qualifying Exam-Part II (MCCQE)</td>
<td>$2,260</td>
</tr>
<tr>
<td>New Certification Exam in Family Medicine</td>
<td>$4750</td>
</tr>
<tr>
<td>National Assessment Collaboration (NAC) OSCE</td>
<td>$2,190</td>
</tr>
<tr>
<td>Self-Administered Exam MCCEE ($68) and MCCQE Part 1 ($68)</td>
<td>$136</td>
</tr>
<tr>
<td>Source Verification Service Fees</td>
<td>$260</td>
</tr>
<tr>
<td>MCC Document and Service Fees: $145 for each document (approx. 6 per application)</td>
<td>$1,070</td>
</tr>
<tr>
<td>Educational Credential Assessment Fees: $98 for each (approx. 6 per application)</td>
<td>$588</td>
</tr>
<tr>
<td>Test of English as a Foreign Language (valid for 6 months at a time)</td>
<td>$325</td>
</tr>
<tr>
<td>Objective Standardized Clinical Exams (OSCE)</td>
<td>$1,850</td>
</tr>
<tr>
<td>OSCE (written part II)</td>
<td>$1,850</td>
</tr>
</tbody>
</table>

Sources: MCC (2015) and Ontario International Medical Graduate School (2016).
Participants explained the great hurt they feel after receiving a notice of denial. “Denial,” as Dr. Eddie said, “hurts more because we know that there is a shortage of doctors. There are vacancies and they refuse to hire us. If there were no vacancies, it would be ok. I can understand.” Dr. Stella added:

To be cast out in a country that says it needs you; that welcomes you as a professional to work and fill a need, and then turn around and belittle your intelligence by pushing you around, far more insults your intelligence. It insults your humanity and dignity even more. Do you know the humiliation for me and my husband? We had everything we needed back home. We were doctors and professors. Now we live like beggars and try to save money to write the exams.

After committing time to studying, upgrading to Canadian English, writing the exams and passing them, going through interviews, and then failing with no explanation, IMDs are troubled. What to do next, how to prepare for future attempts, and how to close this journey and move to something else becomes very problematic for IMDs. The uncertainty is difficult, but giving up after this lengthy and costly process is even more difficult. Dr. Enzo said:

I will keep going through the process of everything the system wants from me here and I will keep doing my best, but if Canada doesn’t want me, I will leave. I will take my Canadian experience and skills, and my wife and child, and go somewhere else.

When I asked Dr. Eddie how he started to look for exam information and whether he could afford the costs, he said:

I found out about CEHPEA and registered with them. I found the information on the website and registered with them, then I applied for their practice exams and tests for IMDs. The exams were very expensive ($1600, $1500, $1600). I work part-time work only to pay for the exams. My jobs are 10–12 hours and I paid about $8,000–$10,000 in a few years for exams alone. I spend all that money I saved and get nothing for it, not even a certificate that I can use to apply for another job or feedback on what I can do to improve my chances for selection.

Additionally, all immigrants interested in medical education in Canadian universities are required to write an English fluency exam. For IMDs, it is the Test of English as a Foreign Language (TOEFL). This test is required regardless of whether IMDs are educated in English schools in British colonies or speak English as their first language. The medical profession uses the result as one of the criteria for testing IMDs’ language skills. The TOEFL has a six-month validity date. This means that IMDs must rewrite the test if they want to keep their application up to date. This adds extra financial burden and preparation stress to their lives.
Dr. Eddie explained the impact of having to rewrite the TOEFL test four times in three years since arriving in Canada in 2010:

You start doubting yourself, doubting your ability, doubting who you really are because you try so much and so hard—blindly, I must say with no guidance—to be better the next time, that you start to doubt your own ability and that impacts your confidence and competence.

I will give you a simple example, I came to [Canada]. I took the first exam and scored well. I took the second exam and did exceptionally well. I took TOEFL. English is my first and primary language (you understand?), and when I talked to people, they tell me English is not my problem and I would not have any problem with TOEFL.

I registered for TOEFL. I did not know how to prepare for it. There are no guidelines. So I woke up in the morning and went to take the TOEFL. The threshold is 100, I came 96 on my first try. A year later, my TOEFL validity had expired. I registered and went to repeat it with greater confidence this time. My score was 86. So, I am not going to sit here and tell you that I am very good in writing a thesis and essays, but I must say that as time goes on, I start doubting how to spell. I am starting to doubt myself on how to spell words or how to create sentences or things in my mind to write an essay. And that’s my problem.

This is my fear! I will take this exam 100 times, and I did not know if I will get better. So, I feel frustrated at this exam which is designed as a standardized exam and can be a good testing tool for non-English speaking people. But I do not feel that it is doing anything to help me and many IMDs like myself.

Dr. Kripp said that he has been writing the TOEFL every six months. Besides the cost of the test, he must take time off work to set his mind to writing it. He cannot tell his supervisor that he needs the time off to write tests. He does not want his boss to know that he is a professional doctor. It is too embarrassing. Everyone in the work place get to know and feel pity for them. Several other IMDs felt the same and explained how they have to hide their identity from their supervisor/employer. They are also advised by places like government skills centres to disguise their CV or the employer will not hire them. As Dr. Kripp said: “The system teaches you to lie.”

Another participant, Dr. TFox, asked me: “Why is the government and the medical profession encouraging us IMDs to write Canadian exams, apply for retraining residency positions, but then never choose us or respect us enough to give some reasons for turning us down?” He went on to explain:

I have been in this country since 2006 and have worked on my English and kept writing the exams. I hoped that one day they will pick me after they see how much I have
improved from since I came to Canada and I am committed to medicine. I have no savings now. I have not had a full-time job since coming to this country. I do not own a home, a car, no nice clothes, or anything to show that I made progress in Canada. I have to write the exams because that is the only way they will consider your application. The other thing is, the exams are expensive and there are no options for cancellation or refunds in case you get sick, or for any other reason why you may not be able to write the exam on the specific date. Things do happen. We are only humans.

Several other participants voiced their frustration with the exams and their disbelief that Canadians in the medical profession treat IMDs with such disdain. As Dr. Stella said:

I hate this. Never in my life have I experienced such humiliation. The people at the program office would not talk to you on the phone. When you go to the office, they treat you with disdain—like what are you doing here…you do not belong here. You are not as good as us. It is so humiliating and dehumanizing. It is embarrassing to say the least.

When I asked Dr. Seena about the support or guidance she might have received from the Ontario medical schools or other offices that deal with IMDs, she responded:

You cannot reach anyone by phone at all. I sent an email to one program. They were kind to respond after several days and told me to basically check the website. I wrote to a few places and one responded and said I should attend the Annual IMG Symposium at the Metro Toronto Convention Centre. I registered for it. It was costly. It was informative. There were many representatives from different university programs and licensing colleges. The people from CaRMS was there too. You get to see the people involved in the profession, but that was about it. I left at the end of the day feeling talked down to and I am a foreigner. There is nothing they can offer you, except that it is a competitive process because many thousands IMDs are competing for a few spots and high exam scores count.

Dr. Flora commented in the same vein:

I work part-time jobs and I try to run a home. I study for the exams at the same time. With a busy life of being a mother, a wife, a worker, and trying to study to prepare for the exams and interviews, when do I find time to read up on the changes of the rules?

I wish they would take the same money used for changing the exams and rules every year and use it to individually assess IMDs to determine who should move forward and help them do so, as well as helping the others to move on to different career paths. Instead, they just put us in one pool and ignore and belittle our intelligence and make us suffer because we were doctors and we want to be a doctor in this country.

This is my fourth year with CaRMS. I was lucky to have some observations and some clinical assist experience. I gained a fair understanding of the hospital settings and how things work because of my Physician Assistant work at the clinic where I take and record patients’ history, read and interpret lab reports for the patient in their language. I speak
four languages and English fluently as you can tell. I work together with the physician to
develop management plan. All this experience meant nothing to the interviewers… IMGs
can easily learn, but they would not allow them that opportunity. It is an unfair process
with open discrimination against IMDs.

Most participants had concerns about the high cost of the exams required by the
profession and CaRMS, and that there are no other benefits from some of the exams. They felt
that the exams were scheduled without any concern for the timelines for registering with CaRMS
and what it means to the lives of IMDs who are new to the country. As Dr. Flora said:

That is difficult in a new job and in a new country and do not know if they will take you
back after the exam. Do not forget that for us IMD, we cannot even tell the boss that we
are doctors, so you have to find some excuses for why you need the time off. If I say I
have to go to the doctor, they think I am sick and cannot do the work. When you go back
the next day, they would kindly inquire and ask you how you feel […] This is
embarrassing and very hard on your emotions and your whole psyche. We do not lie; but
this government brings us to Canada and forces us to do unethical things. I wish they
would take to see the whole process from our side as IMDs.

Dr. Seena also felt very upset about the exams:

You must pay upfront. You do not get a reduction of fees if you wrote the exams in the
past. I have kids and they are sick and I was up all night, I still have to make it and be
ready to write the exam. You ended up just wasting your money […] I am an immigrant
and I am a trained medical doctor. I have never failed an exam. I can easily learn what is
put in front of me and I am sure it is the same for most IMDs. That is why so many IMDs
pass the exams that are put in front of them.

She said to me: “Why you do not ask them to get some IMDs to help them figure out the exams
and exam process for IMDs? [IMDs] are sadly missing in the process. They need to stop wasting
IMDs’ time and money and ruining their families.”

Dr. Gerty explained her perseverance in securing a retraining opportunity before her
timing expires and at significant financial and personal costs:

I have to tell you; the exams are very expensive in Canada. Every year the exams fees
increase in some format and it seems that no one thinks of us IMDs and how we can
afford to pay for these exams, raise a family, and settle in this country.

What I gather from these comments is that IMDs are welcome to write the licensing
exams when they arrive in Canada. If they are not accepted for a retraining residency position in
that year and ask for feedback, they are encouraged to rewrite the exams and keep their grading
active. Some participants felt that the system wants them to continue writing the exam to keep up
their knowledge and skills, while others felt that the residency program only looks at their first score. As such, it does not matter if their scores improve in future years, and all future attempts at writing the exams are futile. In addition, after the introduction of the new ‘recency of training’ requirement (HealthForce Ontario, 2016), neither the program nor the medical profession takes the blame for IMDs’ career termination because the time lapse occurs under the IMDs’ own watch. Previous studies on the barriers and problems IMDs face during recertification found similar issues relating to recency of training (Peters, 2012; Thomson & Cohl, 2011). The IMD saga of rejection and barriers is not a new phenomenon according to these studies. It is a historical attempt to keep the gates to the profession closed to IMDs, unlike other accredited and regulated professions such as dentistry (see Boyd & Schellenberg, 2008).

**IMDs Compared to Immigrant Dentists**

Similar to doctors, dentists are also listed in the Federal Skilled Worker Program (Services Canada, 2013) under the high-demand occupation category as a need for dentists in Canada. Like IMDs, ITDs do not need job offers to immigrate to Canada if they have completed one to four years of pre-dentistry university study and hold a university degree in a recognized dental program (Schulich Medicine and Dentistry, 2016) because they fall within the Federal Skills Worker program of high demand occupation. Once dentists arrive in Canada, they are required to be recertified before they can work as a dentist, the same as professional IMDs. The regulatory body is the Royal College of Dental Surgeons of Canada (RCDSC) and has a similar a development of profession as medicine, with the 1868 Act that declared dentistry as a professional profession in Canada. As in medicine, there are different levels of specialty in dentistry and ITDs are required to register with the RCDSC. They are required to go through an assessment process for a program that leads to a license to practise dentistry in Canada. However, the pathway to licensure in dentistry is much less cumbersome and much less expensive than the pathway to licensure in medicine (Figure 13).

ITDs who have completed a minimum four-year university dental program may apply for advanced retraining through the International Advancement Dentistry Program (IADP), which is held over a five-month period. After successful completion of the IADP, the ITD is then integrated into the third year of the four-year Doctor of Dental Hygiene program, which leads to the Doctor of Dental Surgery program.
By comparison, most IMDs accepted for retraining are required to start at the basic first-year level. There is an Advanced Verification Program (AVP) for advanced IMDs as well, but most IMDs go through the regular CaRMS application to redo the entire specialty training program. This can be difficult and frustrating for experienced IMDs who are senior doctors with many years of work experience, as I witnessed when I worked in the medical school.

It is also costly for the government to provide the retraining and re-educate, supervise, assess, and evaluate IMDs who are already trained doctors and older in years and must work alongside Canadian PGY1 residents in their 20s. IMDs must be re-educated to fit within the curriculum established to train Canadian doctors and to work, thus the added cost to retrain IMDs versus ITDs. After ITDs complete the straight forward Doctor of Surgery program, they are prepared for writing the National Dental Examining Board of Canada exams, which are the same exams Canadian graduates must take, similar to the IMD process. ITDs are then eligible for licensure/registration as a dentist. Their license is portable across Canada. Unlike IMDs who must first do five years of Return-of-Service in an underserviced community, or repay the government five years of fees for breaching the contract, ITDs are free to practice dentistry anywhere in Canada. Moreover, IMDs face greater competition because of the larger number of applicants and the few positions allotted to IMDs for retraining. As such, most IMDs get caught in the cross-section of the PGY1 Pathway to Certification and are never granted interviews or retraining programs, unlike ITDs.

The dentistry program at U of T also has a TOEFL test validity of two years, longer than the six months or one year IMDs. The dentistry program also accepts other English tests such as the International English Language Testing System (IELTS). Although the IELTS is more portable into the US and other countries, TOEFL is the preferred choice for IMDs. This means that IMDs who already paid for and passed the IELTS are still required to write and rewrite the TOEFL, thereby increasing their financial burden. A comparison of exam fees for IMDs and ITDs is shown in Table 12.
Figure 13. Comparison of immigrant dentist and immigrant medical doctor licensure pathway. Source: Royal College of Dental Surgeons of Ontario (2016) and Association of Faculties of Medicine of Canada (2012).
### Table 12

*Comparison of Exam Fees in Medicine and Dentistry*

<table>
<thead>
<tr>
<th>Medicine Application Exam Fees</th>
<th>Medicine Fees</th>
<th>Dentistry Fees</th>
<th>Dentistry Application Exam Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCC Evaluating Exam</td>
<td>$1,695</td>
<td>$275</td>
<td>Application Fees</td>
</tr>
<tr>
<td>MCCQE Part I</td>
<td>$950</td>
<td>$1,000</td>
<td>Component I</td>
</tr>
<tr>
<td>MCCQE Part II</td>
<td>$2,260</td>
<td>$4,500</td>
<td>Component II</td>
</tr>
<tr>
<td>New FM Certification fee</td>
<td>$4,750</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAC OSCE fees</td>
<td>$2,190</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Assessment fees</td>
<td>$136</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Source Verification fees</td>
<td>$260</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document fees at $145 each for up to</td>
<td>$145</td>
<td></td>
<td></td>
</tr>
<tr>
<td>six documents each</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credentials Assessment fee at $98</td>
<td>$588</td>
<td></td>
<td></td>
</tr>
<tr>
<td>each for up to six documents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOEFL with validity of six months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$14,299</strong></td>
<td><strong>$5,775</strong></td>
<td></td>
</tr>
</tbody>
</table>

Sources: MCC (Fees and other Expenses for IMDs) and Royal College of Dentistry (Fees and Deadlines).

The dentistry program for ITDs also offers a refund portion on the registration fees for the exams if the ITD is unable to write the exams at the scheduled time (Table 13). This kind of refund is not available to IMDs. As well, the dentistry program requires fewer tests and exams than the medical program, and the fees are much cheaper (Table 12).
Table 13

Refundable Exam Fees for Dentists

<table>
<thead>
<tr>
<th>Date of Request Prior to Exam</th>
<th>Refundable Fees (per component)</th>
</tr>
</thead>
<tbody>
<tr>
<td>During application window</td>
<td>100%</td>
</tr>
<tr>
<td>More than 90 days but after the application window</td>
<td>75%</td>
</tr>
<tr>
<td>More than 60 days but less than 90 days</td>
<td>50%</td>
</tr>
<tr>
<td>More than 30 days but less than 60 days</td>
<td>25%</td>
</tr>
<tr>
<td>Less than 30 days</td>
<td>0%</td>
</tr>
</tbody>
</table>

Source: Schulich School of Medicine & Dentistry Programs (2016).

Dentists versus IMDs

IMDs are encouraged to keep writing the costly exams and competing in the very expensive CaRMS process even after receiving denial of a retraining residency position. ITDs on the other hand are not allowed to reapply continuously to write the dentistry exams. The participants in my study raised this as a great concern. Eight participants said they would prefer a more direct approach by the CMP. Rather than being told that recertification is a “very competitive process,” they would prefer to be told that they do not have the chance for a retraining position and given reasons why.

In dentistry, the ITD Selection Committee selects the top 100 applicants from the pool of applications. Only these top 100 receive an invitation to attend the Prior-Learning Assessment (PLA) tests that determine their eligibility for the program. In medicine, however, all IMDs who are registered with CAPER can write the exams and apply through CaRMS. They can reapply as many times as they wish. As Dr. Seena said: “Six to seven years ago, one exam cost $600 to $700. Now it is almost $2,000. I cannot save anything, but this is my only chance. If I did not take it, I can lose it.” And Dr. Enzo said:

So far, I paid over $20,000. I spend all my time to study for exams, when I could be working and making money or spending time with my family. I would not give up yet. I am determined to “win” a spot. Canada needs doctors and here I am, I cannot help. Why? It is unfair for the government to send us on this gambling spree. I am a Muslim. In my
culture, we do not gamble but in this country, I feel I am gambling my life because I work to save money to pay for the exams and there is no guarantee, just hope.

Dr. Tila said:

My husband has a good job and can support the family, but I keep looking for part-time work to make extra money to pay for the exams. I have depended on him all these years. I cannot keep asking him for money to write the exams. I have to find work.

**Losses for IMDs**

IMDs suffer significant financial losses as new immigrants seeking and being denied medical recertification to transition into professional jobs. It costs them a significant loss of their life-long savings for writing the medical exams with no assurances or guarantees of positive outcomes for costs of the exams. They cannot seek other professional training or jobs to supplement income while proceeding with medical recertification. Five to ten years spent seeking medical recertification means the same number of years of loss income for the value of their education, inability to engage in financial investments in buying a home, save for retirement, their children’s education or second career preparation. Loss of investment in my view, is the money IMDs invest seeking medical recertification and the earning gaps that occur in continuing to seek recertification after being denied a retraining opportunity.

As shown in Table 14, the age range of the IMDs in my study is from 35–50+ and they have collectively missed a total of 90 work years from the point of arriving in Canada to the time of the interviews in 2013. The number of MD or equivalent years of education received in total is 87, while the total years of postgraduate training is 86.5. The number 52.5 reflects the number of years worked by family doctors and one emergency medicine specialist. The number 86.5 reflects the number of years worked by specialists in anaesthesia, obstetrics and gynaecology, and surgery, for a total of 139 years of medical practice experience. In addition, the data show that these 15 IMDs have been living in Canada for 2–25 years each, for a total of 115 years.
Table 14

_Years of IMD Training and Education (refer to Table 6)_

| Years            | # of Years of MD/equivalent Degree | # of PG Years of Training | # of Medical Practice Years | # of Years Living in Canada |
|------------------|------------------------------------|----------------------------|-----------------------------|----------------------------
| 35-50+           | 90                                 | 87                        | 86.5                        | 115                        |
|                  |                                    |                            | 6 – FM (1 Emerg) = 52.5     |                            |
|                  |                                    |                            | 9 – Sub-specialty = 86.5    |                            |
|                  |                                    |                            | Total Years = 139           |                            |
|                  |                                    |                            | Practice experience        |                            |
|                  |                                    |                            | 115 years no professional work |

If one takes the average income of family doctors and multiplies it by the number of years of loss of income for IMDs (Table 15), the financial loss for 115 years of lost professional level income for IMDs is significant.

Table 15

_Cost for Years of Lost Income for Family Doctor IMDs_

<table>
<thead>
<tr>
<th>Pay Scale for Family Doctors</th>
<th>X 115 years of loss earnings</th>
<th>Financial Loss to IMDs and Government</th>
</tr>
</thead>
<tbody>
<tr>
<td>$310,000 (high income)</td>
<td>X 115 years</td>
<td>$35,650,000</td>
</tr>
<tr>
<td>$144,000 (average income)</td>
<td>X 115 years</td>
<td>$16,560,000</td>
</tr>
<tr>
<td>$61,000 (new graduate)</td>
<td>X 115 years</td>
<td>$7,015,000</td>
</tr>
<tr>
<td>$30,000 (average IMD income)</td>
<td>X 115 years</td>
<td>$3,450,000</td>
</tr>
</tbody>
</table>

Source: PayScale Human Capital, 2026

Even after deducting overhead costs for average and high income family medicine doctors, the financial loss to IMDs is exceedingly high. What is more important, is these figures represent only the loss to 15 IMDs in Ontario compared to the several thousands of IMD who are qualified but denied medical recertification each year.

In 2013, the Canadian Government committed more than 11% or over $200 billion to healthcare (National Healthcare Expenditure, 2013), while still leaving almost five million patients with no access to family doctors and paying high costs to expensive emergency units for non-emergency care. This added cost to the government also burdens taxpayers, a situation for
which IMDs are in no position to help due to lack of opportunities for better paying professional jobs.

**Years of Wasted Income for IMDs**

From this study, IMDs collectively practised medicine for approximately 139 years (Table 14) before coming to Canada. Using a box plot (Figure 14) to calculate the average years of practice of these 15 IMDs shows that 50% of the responses for “years practiseing medicine” falls into the main box. This is a significant amount of work experience that IMDs bring to Canada. Coincidentally, on immigration applications for permanent status in Canada, 24 points are given to language and 25 to education. Yet these weights of work experience mean little to the Canadian government and the medical profession when IMDs arrive in Canada.

![BoxPlot of Years Practising Medicine](image)

**Figure 14.** Boxplot of average number of years study participants practised medicine.

Using a 95% confidence level, the average years worked per IMD range between 4.925 and 13.075. Therefore, taking 4.925 years per IMD and multiplying it by the large number of IMDs who are denied medical re-licensure in any year in Canada, the total of IMDs’ wasted working years is significant and costly.

The histogram in Figure 15 also shows the number of years IMDs practised medicine before coming to Canada. Six out of the 15 IMDs in my study practised medicine for 5–10 years.
Five out of the 15 IMDs practised medicine for 0–5 years before coming to Canada. Three out of the 15 practised for 10–15 years, and one IMD practised for over 25 years. These years represent a lot of skills and experiences IMDs bring to Canada that are wasted. A better system for capitalizing on these skills for the future would be helpful.

**Figure 15.** Histogram of Years IMDs practising medicine.

All but one IMD in this study said that practising medicine and serving humanity is more important to them than making a salary equal to Canadian physicians. Still, I believe it is important to highlight the loss of investment for IMDs resulting from their low-wage and underemployed jobs in Canada, as well as the loss of taxable contributions to the government. The calculation I used to determine these costs is shown in Figure 16.
Financial Losses and Drain

If the approximate income for a family doctor is $144,000 per year and the IMD earns a salary as a security guard at $30,000 per year,

the IMD loses

$144,000 average expected salary less $30,000 average current salary

= $114,000 loss income per year for IMDs

As per Table 14, the 15 IMDs lost approximately 115 years of professional work earnings as a medical doctor with an average of 7.67 years on average lost per IMD

If the IMD who earns $30,000 per annum, loses $114,000 per annum, for 7.67 years of life in Canada

the IMD will lose $114,000 loss salary per year x 7.67 years average years lost

= $874,380

Therefore, a Family Doctor IMD in Canada loses approximately $874,380 for 7.67 years work

Similarly, Royal College specialists earns $190,000 per year average, minus the $30,000 income earned as a security guard put the specialists in arrear of $160,000 loss of income per year

Taking the same formula as family doctor above, the Royal College specialist loses in 7.67 average years of living in Canada not working as a doctor:

$160,000 x 7.67 years

= $1,227,200 losses

Per each IMD as taxable income

Financial Loss = waste to IMDs, the government and people of Canada

Figure 16. Loss costs: Financial losses and drain.
Losses for IMDs: Income/Investments

As this chapter focuses on the economic quandaries facing IMDs, in this section I provide an example of how much income an IMD loses after immigrating to Canada. I calculate that among the 15 participants in this study, an average of 7.67 years is lost per IMD, minus the earnings at present status (Figure 16). This is a significant loss of income for newcomers to Canada and the Canadian economy.

IMDs in this study were concerned about the health of people who do not have access to doctors in Ontario. They expressed concerns about the helpless people in Sub-Saharan Africa and other developing countries. They expressed anger that their skills were being wasted while human beings are suffering and dying. Dr. Artmad said, “It is a humanitarian atrocity that the government cannot find a better way to assess IMDs and use IMDs skills. It is not cheap to train a doctor and here thousands of doctors are wasting.” He is willing to move to another country to care for the sick, but moving would complicate his Canadian citizenship application, thus he must wait in Canada.

Many of the IMDs in my study regretted making the choice to come to Canada. Some felt that they have fallen into a trap of despair and are now living in hope. They packed their bags, uprooted their families, said goodbye to loved ones back home, as they aspire onwards for a much better life in Canada. Returning home as a taxi driver or dishwasher would not be easy and several IMDs (Drs. Enzo, Flora, Stella, Vera, and Gerty) said they plan to return home as soon as they have a good job. They see other IMDs like Dr. Bashir (Hamilton Spectator, 2007) finally being accepted for a residency position after many years of sacrifice, and they adopt the same hope for themselves. One participant, Dr. Flora said: “The CaRMS match is like playing the lottery” even though she does not play the lottery because she is Muslim and Muslims do not gamble. She wishes the profession would be more specific as to what they are looking for in candidates. This would help her prepare better for the interviews. It will save her a lot of money. She has had several interviews since arriving in Canada in 2005. In 2013, she is still waiting for a retraining residency offer after many successful years of CaRMS application.

Health Minister Eric Hoskins said that the uncontrolled high billings by some doctors leave less for family doctors and others. He suggested that the Ontario Medical Association should step in and re-balance the fees to help eliminate deficits in the government’s budget or the
government would be forced to make changes (Ferguson & Boyle, 2016). In Chapter 10, I suggest creating a diversity program and offer other recommendations for saving healthcare costs while capitalizing on IMDs’ human capital to meet aspects of community patient needs.

**Taking a Chance—Gambling**

Taking a “chance,” “gambling,” or “winning the jackpot” are not terms generally associated with the medical profession and doctors. As Beckert and Lutter (2013) argue, social scientists tend to agree that there is an inverse relationship between low socioeconomic status and playing the lottery. They argue that lottery players systematically overestimate the very low probability of winning (p. 5). Tripoli (2014) shows that poorer people tend to treat playing the lottery as an investment opportunity rather than as entertainment. They see it as their “Hail Mary” to gaining something big and far-reaching. Beckert and Lutter (2013), Clotfelter and Cook (1987), and others show that winning is not the ultimate answer for most people. Instead, they value the satisfaction of trying for a good outcome. As Dr. Artmad said:

> I do not intend to give up and take defeat. I am a medical doctor by nature and I am in training again. As long as I am young and have health and energy, I want to care for the sick. That is my goal.

Dr. Flora has been very successful with the CaRMS application and has passed the bottleneck on the PGY 1 Pathway (Figure 4) and received offers for interview as Ontario medical schools, but has not been successful in receiving an offer for a retraining residency. She said:

> I am a Muslim. Muslim people do not play lottery or gamble but that’s what I have done in the past years. This is bad. What can I do to prove myself? I cannot get feedback what I did wrong or how I did at the interviews to help me prepare better in the future.

Professional IMDs immigrate to Canada for a better life and for better educational and career opportunities. As discussed in Chapter 6, they arrive as self-sufficient doctors, highly motivated to obtain their Canadian medical license. Their lives revolve around the goal of recertification, and their needs are intertwined with this goal as central to their focus. Paying approximately $14,995 to write the Canadian medical exams (Table 12) and go through the application process, collecting all supports data, verifying them by notary public and uploading them to the CaRMS database results in added reduction of their financial resources. Having to reapply in future years causes a further reduction and eventually drives them into a lower socioeconomic status bracket.
Giving up their quest after depleting their resources has significant consequences for their lives and identity. Despite their social and financial downward spiral, fixation on winning a residency position becomes more intense. With so much investment of finances, time, and educational resources, they imagine a light at the end of the tunnel. There is still a probability that they could be selected after five or ten years, similar to IMDs in the past such as Dr. Bashir. Consequently, many adopt the me-tooism attitude (Gish & Wilson, 1967), that if Bashir or others can be successful, so can they. Playing the game and hoping to get a coveted winning retraining spot (Beckert & Lutter, 2013, p. 5) entices IMDs to take a gamble and overestimate their chances.

The IMDs in my study did not see themselves as being poor, even though their low income and lack of professional jobs put them in the ballpark of a “poorer” socioeconomic class. Instead, their destined goal of reaching self-actualization makes them feel that they are making continuing investments (Tripoli, 2014) in their personal and professional life.

**Conclusion**

IMDs come to Canada as economic class immigrants to settle, support themselves, and make contributions to the country. As Canada continues to accept and welcome refugees, young international students, and workers from developing countries with different cultures and languages, it seems apparent that IMDs can contribute to the medical profession by delivering care to a greater diverse patient population. Passing the Canadian exams renews their medical confidence and skills, and triggers their aim to take a chance on one of the coveted positions earmarked for immigrant doctors. Despite the costs, frustrations, humiliation, embarrassment and low-income level of IMDs, motivation to gain medical recertification overlook these. Prior to coming to Canada, they either reached or were reaching self-actualization in their medical careers and lifestyles as successful professionals. It is usual for immigrants to be motivated to look ahead to bigger achievements and higher status in their new homeland, and IMDs are no different. However, their lives take a different turn from their hopes and expectations after arrival in Canada. Facing firstly, un-recognition of credentials and other enormous challenges in the recertification pathway, and coupled with determination to reach self-actualization, IMDs turn to “gambling” for an opportunity to be successful in re-licensure to continue their medical career.
Taking a deeper look at their financial situation, I was surprised to see the difference in the average income of a security guard, a family doctor, and other specialists. It was interesting to get a glimpse of how little highly educated IMDs are able to contribute to the country’s economy through taxes, pension, unemployment insurance, savings for retirement, buying a house or a car, or other forms of spending. Rather than being proud, as immigrant parents tend to be in Canada that they are securing a better future for their children, IMDs suffer economic hardships that force them into an unexpected poverty lifestyle, which is obscure to them. They immigrated to Canada to be proud members of the society and medical profession. It is my hope that stakeholders of the medical profession will re-think the value of IMDs’ human capital as a resource to Canadian society and medicine, and explore new possibilities for capitalizing on these resources. Heeding the financial losses to IMDs, the healthcare system, and the government of Ontario in having millions of patients with no access to family doctors or access to doctors who can understand their language and culture, I argue that the loss is too severe and costly. I urge a revisiting of IMDs’ skills and talents for future contributions to the Canadian medical profession and the diversity of patients in Ontario. In the next chapter, I explore the personal, professional, and social impacts that a denial of medical recertification has on the lives of IMDs to further show the findings of this study and make a call for change.
Chapter 8

Results Part Three: Professional, Personal, and Social Impacts

This thesis seeks to understand the experiences of IMDs after being denied recertification and despite meeting the requirements for retraining. The previous two chapters analyze the motivational drive and economic quandaries that affect IMDs in Ontario as they continue to apply for re-licensure. This chapter explores the personal, professional, and social impacts on their lives. Their success at the Canadian exams and meeting the other requirements for retraining gives them renewed confidence that they understand and can practice medicine in Canada. Every successful CaRMS application gives them new hope of eligibility for selection. Every denial brings frightening disappointments. IMDs become a year older and jump from being in their late 30 years or 40 years old to their early 40s and 50 years old during the recertification process. They move further away from recency of training. Their earning power remains at the underemployed level in low-wage jobs. With no professional job prospects, no opportunity for increased earning, no compensation for exam costs, no feedback on their performance, and no specific career guidance, fears start to set in. Seeing the shortage of doctors and their rejection from filling the need is disheartening for IMDs. Having to explain to family, friends, and extended communities why the government is not hiring them is embarrassing. Feeling like victims as described by Dr. Flora or prisoners as explained by Dr. Artmad in their new homeland is disconcerting.

What can they do? What else can they do to fit in or be recognized? Is it their fault for immigrating to Canada as a visible minority IMD? Is it discrimination? Should they move to another country or return home if they want to maintain their medical status and profession? What do IMDs tell their families when they deplete the family’s financial resources and still have no jobs or certificate to show for their spending? What should Dr. Eddie tell his little girl when she asks if he is a doctor yet? This chapter takes up the comments made by my study participants to answer the research question, but first an overview of the findings.

Overview of the Impacts

I asked the participants to explain how being denied a chance to practice medicine impacts their lives. Their responses were thick with emotion. While some had experienced their first denial, others had been denied several times. The despondency, frustration, helplessness,
and fear were greater for those who had been in the process for a longer time. Their passion and deep yearning to be with patients, touch them, and help them heal, work with other medical professionals, and engage in new learning were very emotional. The desire to be back in the hospital and in the profession, as promised through transitional programs by the government, came across very loudly. Gish and Wilson (1967) wrote that physicians have a longing to be with patients. “To care for them is natural” (p. 495).

This longing is particularly evident in the participants in this study. Dr. Gerty who is the only participant who chose a Plan-B non-clinical medical career to tie her over until she gets settled in Canada, explains her longing desire to work with patients again. As a senior Ob/gyn specialist with a master’s degree and many years of work experience in a medical setting in Toronto, she feels capable of practicing her profession skillfully at any time, but she has been advised to return home to gain recency of training skills since she has not practice medicine for more than five years. Then we have Dr. Ahuja who immigrated to Canada as a pediatrician from India. He decided not to get frustrated with the impossibilities of becoming recertified in Canada. He decided to learn to drive and became a truck driver (Aulakh, 2011). On board a flight from New Dehli to Toronto, a pregnant passenger went in labor. The call was made for a doctor on board. As the only doctor, he responded, “kicked into high gear,” turned the passenger cabin into a birthing room within minutes of improvising and makeshift instruments and performed an emergency delivery on the spot after being out of practice for several years. Forty-five minutes later, a baby was born over Kazakhstan (p. 1). Dr. Ahuja is one of thousands of IMDs, in addition to the 15 participants in this study, who could contribute to the delivery of healthcare in the GTA and across Ontario. After away from medical practice for eight years as a pediatrician, learn to drive a truck and being on the road, in a medical emergency his medical school skills came back instantaneously and successfully.

Why has the medical profession introduced a 3-5 year recency of training ban against IMDs if the skills can re-emerged instantaneously? What makes IMDs different from other professionals is that they are physicians with four or more years university studies to earn a doctor of medicine (MD) or equivalent degree. They spend many long years in postgraduate education, have close integration with the profession and with patients’ personal lives, developed a passion to care for humanity. The medical experience gives them a deep consciousness for the life and well-being of people. They have a different outlook compared to other professionals.
such as engineers, accountants, academic scholars, or researchers. Unlike scientists who are committed to the precise search for the truth, IMDs are physicians whose “foremost dedication [is] to the service of those persons requiring his/[her] professional skills” (Gish & Wilson, 1967, p. 495). IMDs are educated professionals, highly motivated to reach their career goal in medicine.

Victims

A hurtful thought for most of the participants was the feeling of being tricked into believing that there are jobs in Canada for foreign doctors; that, if they pass the Canadian exams, they will be eligible for a license to practice. Other participants see themselves as “victims” in Canada (Dr. Flora). They spend their financial resources paying for the exams to secure the opportunities promised by the government and in the end, have nothing to show for their spending. Several IMDs said that if they knew their foreignness, immigrant status, and ethnicity would restrict their chances to less than 10%, they would not have immigrated to Canada or would have sought alternative career pathways earlier. They are here but cannot leave the country because it is too costly and because leaving will affect their application for Canadian citizenship later.

IMDs are restricted from working with other doctors and other areas of medicine that deals with patients care because they are already trained professional and licensed doctors. It is restrictive for them to work without a license to gain medical experience to support their application for retraining programs. The participants expressed frustration at being victims of a process that categorizes them as incapable to engage in training or practice of medicine without a fair chance to prove themselves or gain any Canadian experience. They feel placing them in the same competition with CIMGs for the same number of positions is unfair as CIMGs get preference over IMDs. Dr. Flora received consecutive invitations for interviews several years in a row, but was never offered a retraining position. When I asked Dr. Flora about her experience seeking medical recertification, she responded:

Struggling through the whole process for medical recertification is so long and complicated, it is disturbing for me. There is so little help from anyone. IMDs start to feel like outsiders and second-class citizens, as if we do not belong here in this country.
She continued:

Facing negativity and rejections from university program directors’ offices, with no clear explanation for these attitudes is very upsetting for us as newcomers in this country. We are new to this country and need to take time to learn how things are done. If they do not want us here, they should not bring us to suffer...

And it gets worse from here, because now they put us in the same pool with the Canadian IMGs—nothing against Canadians—who were not accepted into medical schools here and went to international countries to study medicine. However, they put us in a more disadvantaged situation when we have to compete against Canadians and not among IMDs.

**Alternative Jobs Versus Perseverance for Recertification**

Some IMDs decide not to proceed further with recertification because the competition is too brutal. They find other non-medical and underemployed jobs, unmatched to their education and qualifications while others such as Dr. Maboo decided to return home. Accepting non-professional and underemployed jobs means taking a significant financial and personal loss. Learning a new career is challenging, costly, and uncertain. It provides no guarantee of a better job. IMDs also find it frustrating and embarrassing to sit in a classroom with younger students. They try to compete with them for good grades and for what, as Dr. Kripp said, are really “young people’s jobs.” Younger IMDs, such as Dr. Arju and Dr. Tunde, found it less embarrassing if the course was at the MA level in clinical research, public health, or community/entrepreneurship. Most IMDs in this study said they were excited and determined to go through the medical recertification process. Years later, the signs of exhaustion had worsened. There are few options for IMDs to get honest feedback or help to succeed. IMDs worry about how much longer they can keep trying. As Dr. Vera said with a sigh:

They are just killing me right now. Last year I did not get through. This year is the same, but I cannot find out what is the reason … what kind of improvements I should make to improve my chance next year. I will be here seven years. I do not know

Dr. Flora responded to the same point starting off with a question:

What is my problem? I do not know. …Can I find out what my problems are? For example, I tried two times in Ontario and after I failed, I said I have to do something, like go to another province or whatever. However, every province has its own rules and regulations and most programs will not take you if you were out of practice for three or more years. That is a problem for me.

Another participant, Dr. Artmad, said:
Everywhere in Canada, I send applications, CVs, letters. This is a very time consuming and expensive job and very seldom, someone gets back to you. Only one recruiter from Alberta sent me something this year. He said he looked through my application. Because I did not work for the last five years, I was not eligible. If I get some recent experience, I could try again.

When you overcome so many obstacles with immigration, settlement as a newcomer in a foreign country, learning a new culture, pass the exams, you try to make sense and understand the profession and how to navigate the system and then you are measured against someone half your age and half your skills and experience…does that make sense? Of course you will fail, then that is bad. Very bad. What do you tell your kids? That a 25-year old knows more medicine than his father who has practiced medicine for 20 years? Is it poor planning by the profession or insensitivity of the feelings of us IMDs as human beings?

I asked Dr. Artmad how he felt about being a senior physician back home and then being denied a medical license in Canada. He said:

For people like me who have been trained for years and years, and with the background here for doctors, and the skills I have as a surgeon, I have passed all the exams. There are some places where the need is very great, but yet there is a restriction on how many IMDs the profession will take to retrain from the majority of skilled IMDs like myself who get turned away.

The Canadian evaluating exams are expected to evaluate IMGs to see that they are par to Canadians…You know, I agree that the education system and medical training here is good, but ours is very good too you know... For me, I think new trainees in Canada lack this broad cultural expertise they bring as a mature doctor to Canada. However, this is not recognized as valuable by the Canadian system.

Another participant, Dr. Enzo, said:

In my country, we have that unique skill of patient diversity. And even with low resources, we had to think differently and quickly on how to provide the best care possible with the resources at hand. Doctors like me can really bring new skills and expertise that are missing in the Canadian system and I can help with the Canadian doctor shortage problem, but it seems that there is a perception that IMDs like me are second-class people.

Historically, physicians have fought to achieve dominance and control of the medical profession (Blishen, 1969; Friedson, 1970a, 1970b; Naylor, 1986). Whitehead (2011) adds that the construct of a “good doctor” is also historically derived. It is socially negotiated as a means of upholding the privileged place of the medical profession. Canada has the option of repeating historical norms or reconstructing to embrace the new 21st century. In the case of medicine,
peoples’ lives are at risk, while qualified IMDs live frustrated, demoralized and humiliated lives. The next section explores the professional impacts on IMDs after receiving a denial for recertification.

**Professional Impacts after Receipt of Denial**

The participants in this study expected to upgrade and compete for medical recertification but none of them expected to have their professional career, status, and identity taken away after arrival in Canada. They come as economic class immigrants with intention and motivation to overcome any personal and financial barriers. They looked forward with excitement to learn new Canadian medicine and advancing their knowledge to be competitive but did not expect to spend their entire life savings and several years of futile attempts for recertification with no returns for their financial investments. Some participants made alternative plans for work and gave themselves some time to settle and understand the process before proceeding with medical recertification. Dr. Gerty and Dr. Arju came with a plan to work in non-licensed areas of medicine while understanding the system and prepare for recertification and found themselves utterly dismayed at the experiences as newcomer immigrant doctors in Canada.

*Dr. Seena* said: You stand out because of your colour, no doubt. You do not even have to say you are an immigrant, but it is ok. At least nobody tells you anything when you walk down the streets. You are just a foreigner among all the foreigners here, and that’s it, but the minute you start to say you are a doctor, you get the feeling that you are a foreigner and you do not belong here. The treatment is different.

*Dr. Stella* said: You are a foreigner. You do not belong here.’ Call this paranoia, but it is not. I feel it. We are trained doctors. We are trained to be compassionate, nurturing, and gentle professionals. We are trained to care for our sick and vulnerable patients. To be treated the way they treat us here is very humiliating and dehumanizing. Why bring us here if they do not need us?

In a similar vein, Dr. Kripp said, “Never in my whole process with the immigration application and speaking with the people at the MCC [Medical Council of Canada] office in my country, have anyone told me that I should be prepared to become a manual labourer or be a pauper in Canada.” He continued:

The MCC centres make people feel that if they pass the exams, it will be easy for them to come to Canada and work here as doctors, but once they immigate, this is the end of the story and all the promises that there are jobs waiting for these folks in Canada disappear.
You are on your own. You join the pool of other IMDs while the MCC centres make a business from the local people…

Thirteen of the participants felt they were denied a chance for recertification because the requirements, timelines, tests, exams or experiences needed are not clear. Fourteen participants said that the requirements and process for obtaining interviews are not clear. Nine said that the testing and other requirements shift all the time and they cannot keep track of them. Eight participants indicated that each province in Canada has different requirements. This makes it very difficult to keep up with the different deadlines and tailor their applications. It is more difficult because it is almost impossible to speak to anyone for clarification says Dr. Enzo. Eight participants said the process is unpredictable. Dr. Maboo, who lived in Vancouver before giving up on the system and returning home, explained:

The pathway for a license to work as a medical doctor is different by province in Canada. I have to know all the pathways in the different provinces in Canada because I was willing to move to anywhere in Canada where I can find work. It was a very confusing process. […] I cannot get to know all these requirements for each province and run from province to province as a new immigrant in a new country. How do they expect me to do that?

I brought my savings to live on while I prep for the exams full-time, but the money goes fast and six months later, you are no further ahead. […] Also, I cannot juggle my energy and double the time for learning the different pathways and for applying to different provinces. It was expensive to go to the different places to meet with program directors to understand the process and get advice.

Dr. Vera commented on the disconnect of what the medical profession says and what it does:

For example, if they say that there is a shortage of doctors and we know that that is true because of continuous reports and statistics reported in the past years since I have been in Canada, then, yes, you have a need for doctors, but why do you not want to fill that need?

These uncertainties and inadequate guidelines confuse IMDs and create major impacts on their lives. The profession places emphasis on recency-of-training as a problem for IMDs as well, yet it accepts IMDs who have been out of practice beyond 3-5 years, such as Dr. Bashir (Hamilton Spectator, 2007) who was selected several years after arriving in Canada and many application attempts later. If recency of training is critical to IMDs’ ability to engage in retraining, Dr. Ahuja (Aulakh, 2011) did not loose his skills. He was a pediatrician and was able to deliver a baby safely in an emergency setting thousands of feel in the air.
Dr. Stella said she has no idea why she was not accepted for a position. She said nobody gave any feedback. She scored very high on the exams. She writes and speaks very good English. She grew up in a British colony and educated under the British education and medical system in the West Indies. She said:

I don’t know what to do. My husband is gone. I have my two children to look after. With my job as a coffee server, I cannot afford to pay for the exams and keep up with other IMDs to compete. I only now have to hope and pray that my husband gets through. This system is bad. It brings people to Canada to ruin their lives.

Dr. Kripp echoed Dr. Stella’s words:

I am a doctor and a professor. I was trained as a doctor under the British system. I lived as a doctor for a long time. Back home everybody knows me as a doctor and a professor. I am here. I am ready to do whatever the government and the profession wants me to do but the system in place for IMDs is not welcoming. It is as if it is designed to “trick” you. We are not kids.

Canada needs to put a better process in place to stop hurting people like me and eliminate the waste of educated professionals’ education and capital. I have been here so many years, have my health, strength and commitment to succeed in this new country, and I am continuing to face social and economic hardships. The thought of not being able to work in a professional capacity and the longer I stay away from it, the harder it will be, is very upsetting. You have to be in the IMD “shoes” to understand what this means to me, my family, and the people in my community here in Canada and back home. Do you know how people talk about Canada and doctors?

Another participant, Dr. TFox, asked why the profession calls it “training” in medicine. He said:

At the end of the medical program, the profession expects people/physicians to be experts and patient oriented. But, if they are trained, they are not experts or patient oriented. Training is when you are trained to do something with precision, but all humans are different…Patients are not like a machine that you can predict, tighten some nuts and bolts, and fix them. So, you see, for me, many things are completely new. The approach is different. That is why I will never give up…For me as a new immigrant, everything is completely new for me. That’s why I never give up yet. I will try again and do everything I can to get a proper retraining spot one day.

The participants also felt that because they are encouraged to rewrite the exams and reapply to CaRMS, by HealthForce Ontario, residency program offices, the IMG Symposium, and others in the medical profession, they do just that and remain hopeful. They believe the advice of these organizations. If they are trying, they will succeed, despite skepticism, confusion and impossibilities, but as discussed in the next section, if faculty members are saying that there
is no hope for IMDs and they should make a decision to end their career, there is really no hope for IMDs and this is quite different from what the government promises IMDs.

**Career-Ending Zone**

In Thomson and Cohl’s study (2011, Vol 1), a faculty member from an Ontario Medical School commented that “the stakes are high. It is a career-ending decision for IMDs in Ontario medical schools” (p. 1). Although this is only one comment, it is troubling that it is coming from a faculty in a medical school. It is disheartening when one considers how much it costs IMDs to immigrate to Canada, to prepare and write the exams, and how much income they lose from not being able to work as doctors or in the field. It is also disheartening to hear that Ontario medical schools do not know how to assess IMDs’ applications (Thomson and Cohn, 2011).

IMDs put their trust in the medical school and administrators to do a good job in judging their ability. Their future lives are dependent on these decisions. They trust the professionalism of the school to give them fair consideration. However, if the schools and interviewers have preconceived views of IMDs even before seeing them or their application, then fewer IMDs will be selected to join the program as has been shown already (Association of Faculties of Medicine, Data Point, 2011). This does not contribute to fair assessment and equity for IMDs. Figure 17 shows the number of positions filled at the U of T by Canadian graduates and IMGs (U of T Postgraduate, 2015), of which less than 50% may be IMDs (Association of Faculties of Medicine, 2012).
Figure 17. U of T Postgraduate Medical Education 2015 Annual Report.

Source: 2015 1st iteration PGME CaRMS Match Results

In this 2015 match, the highest number of positions was allotted to the Family Medicine program (20 in total of IMDs and CIMGs), therefore, still only making room for about 10 IMDs to gain access. U of T has done exceedingly well in filling its quota of IMG spots as compared
to other Ontario and schools across Canada. In 2015, while U of T filled all its positions, a total of 54 positions remained unfilled across the rest of Ontario, 91 remained unfilled across Quebec, and another 59 remained unfilled across the rest of the country (PGME Report, 2015 - CaRMS 2015 Vacant Positions). Again, while there are vacant positions for IMDs, IMDs are not selected to fill the vacancies, leaving them to face the unexpected “career-ending decision.”

I asked Dr. Enzo if he would try doing some other work in medicine, such as being a professional nurse, since he received denial for residency retraining. He responded:

I would not want to go and be a nurse. I am a professionally trained medical doctor. I came here because I want to excel in my profession, because it is a good country for my family, and because there are vacancies for doctors in this country. But this is all so stressful and not healthy for people like my family and me.

You probably heard this; the brain works better, like a child’s brain, when it is triggered to learn new things. You become like a child again with a child’s brain when you face the challenge or should I say, the excitement, to learn new things. It’s like making a doctor twice in the case of the IMDs…I was once trained as a doctor. I come here and I see all the things I want to do as a doctor, many of which were not available to me back home. When I am studying for the exam, I become more curious…I am gaining all this additional theoretical and high-level knowledge and skills from studying for the exams. The more years you deal with the process, the more knowledge you gain, the more excited you become to want to practice medicine, and the more frustrating life becomes.

When I drew the participants’ attention to the cost of preparing for and writing the exams and asked why they keep reapplying if the cost is so high, they had similar responses. Dr. Kripp explained:

They said they need doctors. They accept me to come to Canada…I was a senior doctor back home. I came here with my family and tried. Yes, I tried and tried, but now I just gave up.

When I first came to Canada in 2004, I came to work as a doctor. I had high hopes of getting into medical practice here in Canada. I wrote all the exams MCEE, LMCC, QE and passed them all. I applied for residency because I met the requirements that were listed on the website. My application was accepted by CaRMS five times, but the programs I applied to never call for an interview… I went back [home] in October 2007 and since then I keep coming and going because I do not want to lose my skills…In January this year (2013) I decided I am not going back. It is too tiring and unsettling. I have to leave my family for months at a time. I am tired and this hurt. It hurts badly. It yanks your livelihood straight from the inside….
You cannot give up something you did all your life so easily. It tears your inside apart...[pause]... it tears you up. The worst for me is, I was a well-known doctor back home, and now I lost everything. I think twice now to go back home.

Another participant, Dr. Flora, said:

I immigrated here for a brighter future for myself and my kids—to live in a more peaceful, democratic and westernized country where there are more opportunities for my children. It is a safer country for kids. And because there is a shortage of doctors in Canada, I thought it would not be difficult to get a license to continue to practice medicine here...I received interviews four times in the last five years and all the interviews have been the same... How can they judge how I am going to be a good doctor to patients from a 15-minute interview without knowing much about me? It doesn’t make sense that they can interview a stranger like me in 15 minutes and decide if I am good or not.

When I asked her if she had thought of doing another job given that she had not been accepted for retraining after five attempts, she said:

No, I never thought of doing anything else. I always wanted to study and practice medicine. Taking that away from me is like taking away my “dream.” I cannot see myself working in a factory job or restaurant or cleaning. That will kill me.

The arbitrary and subjective exams, the selection criteria, the processes, and unclear guidelines place IMDs in an inferior position. They are expected to redo the basic exams and answer skill-testing questions on subjects learned in medical schools, for some IMDs, this could be 15 or 20 years ago. The closed-door approach of university and program offices where IMDs cannot speak with individuals directly to obtain information regarding their applications is also a problem. The information is given on the website and causes uncertainty and indecisiveness. The ambiguity of the information causes delays in how IMDs should proceed in the professional career stream in Canada. It leads to their inability to make proper career decisions on a timely basis because figuring out the information and going through the process of recertification can well take one to three years. It takes them further away from eligibility for a medical career. They need to work to survive and care for their families. It becomes too late to seek an alternative career because of lack of finances, age, and the uncertainty of choosing a second career. They end up facing the inevitable “career-ending” plunge.

IMDs’ chances for a career in medicine dissipate as they continue in underemployed low-wage jobs. Faculty members in Ontario medical schools feel that there are too many “very good
[IMD] candidates [and] nobody really knows the best way to choose” (Thomson & Cohl, 2011, p. 3). Meantime, Walsh et al. (2011) recognized the benefit of IMDs for medical education in Canada:

The Canadian social contract requires that IMGs be incorporated into postgraduate medical education; there is a social responsibility to integrate immigrants into the Canadian workforce; and they bring a diversity of experience and cultures to training programs and to patient care. (p. 13)

What is not clear here is whether IMGs in this case refers to immigrant doctors as in the past or in interpreted as international medical graduates. If it is the latter, then IMDs still fall short in filling these positions as CIMGs are chosen over IMDs from visible minority countries. In reality, IMDs endure marginalization and discrimination from the profession and their credentials, knowledge and culture are of lesser value than the CMGs and CIMGs. IMDs’ diverse international experiences are not recognized as equal contributors to the medical system (Zulla, et al, 2008). Placing IMDs in the same pool as CIMGs and offering more IMGs spots to CIMGs is a shattering blow for IMDs. It affects their self-confidence. It plays with their emotions and their beliefs about their reputation and professional career ability. While some IMDs give up hope for medical recertification for various reasons, others, such as the IMDs I interviewed, live in hope that one day, fairness and justice will prevail. One day, they will be selected for a retraining spot. I asked Dr. Gerty if she would change her career. Her response was: “Oh no no!” In the next section, I expand further on the professional, personal, family, and social impacts IMDs experience.

If I Can’t Practice Medicine

As a strategy of grounded theory in qualitative research (Creswell, 2003) allows me to ask the participants similar follow-up questions to gain a deeper understanding of the question and impacts on their lives. I asked a follow-up question: If life as a doctor was good back home, why give it up and come to Canada? Dr. Gerty responded:

My life was good. I was working there and was happy. I had all what I needed but my husband was on a contract job as an engineer in Canada. I came to visit him. He wanted to stay in Canada for his business. There were jobs for doctors advertised, and I decided I would like to stay here too. We looked into the immigration requirements, applied and we were granted landed status. It didn’t take long…but the obstacles to get my license was difficult.
I wrote the exams; passed them, and then nothing…I keep trying. Several years later I am still trying. I feel very frustrated at work. I work in a clinic as a technician. I see the doctors and I know I can do what they are do…yet I cannot get a chance.

When I asked her to elaborate on her frustration, she explained:

Oh, I feel some days I am so depressed. I sit at home and say oh my God, I have to keep trying because I know I can do it. But then I feel so depressed because I have a family and I have to get going and take care of them first, regardless of how I feel. They are getting older and how long can I try? But it is very frustrating because you know you can do it and you are not able to do it because of the language difference, because the older you get, the harder it is to reach that goal and for them to take you...

Again, IMDs are coming to Canada because there are job vacancies. But, IMDs feel there is little consideration of how they fit into the medical profession. Dr. TFox explained his medical journey as follows:

When I was in university medical school, some of my friends in university decided to withdraw completely from medicine and chose different careers. Their first years in medical schools were ok, but once they started the clinical training and having to deal with patients in the hospitals, some of them found that they could not deal with patients in the hospitals, sick people, and with dead bodies for the rest of their lives. Some of them decided to go in astronomy, physics and some into engineering, but I decided to stay in medicine… it was very hard to get into medical school, because it was such a very prestigious profession… I was one of few in my year who stayed with medicine.

I then asked if he sees himself doing any other kind of job besides medicine since it is very difficult to get a retraining position in Canada. He responded:

The system which is in place for assessing and hiring IMGs, although not perfect, forces IMGs to persevere and become more determined to achieve their goal to practice medicine in Canada. It does not give any leeway to IMDs and I am not giving up. I strongly hope that eventually my efforts to register with the medical professional body in Canada will finish successfully.

Strauss (1975) argues that medicine, as a licensed and regulated profession, is guided by strategic planning and goals interrelated with the government and other stakeholders. Training doctors in specific institutions, such as hospitals, schools, and clinics, and training them alongside physicians, paramedics, and other medical professionals with specialized skills is part of medicine (Strauss, 1975), particularly if it is focused on a specific patient population. As such, IMDs’ human capital may not be as transferrable as it might be in the business sector, industry, or other institutions. Tests, exams, retraining programs, interviews, and other assessments make
perfect sense to IMDs. They know the seriousness of a profession that deals with people’s lives. They know the importance of knowledge and skills to maintain medical expertise. They have no objections participating in exams, evaluations, upgrades and retraining to prepare themselves for work in the profession.

When asked if the examination and testing of IMDs is too rigid and if it contributes to being denied entry to the profession, Dr. Seena said:

Physicians are all different and I agree with all the evaluations and testing to weed out the not so good physicians. We take people’s lives in our hands and wherever we practice, Canada or elsewhere, we must be properly trained. Not all doctors are good doctors or, I should say, not all have the right level of training and education. If people graduate from unknown universities where education is not up to par with the more advanced countries like Canada, yes, they should be tested for competencies, suitability, etc. However, it should not be a one-way or one-answer system like the scale of 1–10 that is used for measuring pain.

For education, I have passed the exams they use as an evaluating tool for IMGs like me, and with high marks. For the skills, I passed the CEHPEA OSCE and OSAT exams, so how can they say I do not have the skills?

She continued:

Not only have I passed the exams here, but my training is accepted in the UK, but Canada still says that I am not good and they are much better than the UK or the US. I personally do not think doctors are so different from country to country.

When I asked Dr. Stella if she will seek out another career if she cannot practice medicine, she became upset and said:

That’s what I cannot understand! Why should I? That is what CEHPEA and HealthForce Ontario try to get you to do. I go for advice for writing the exams and preparing my application for CaRMS, but they discourage you and talk down to you. I have no choice but to back off. They do not want me. Is that the way to treat people?

My husband and I were both practising medicine back home. We gave up everything to come here. […] He came first and completed a fellowship and they encouraged him to apply to come back to work as a doctor here. They told us we can get a license to practise medicine here. We both passed the exams. I am serving coffee for a living. I am just ruined all around… [pause and being very emotional] … job, career, family, but I have to stay strong for my kids and their future.

She continued,
How can I do something else? I will have to go back to school. I am a doctor. What can I do? How many years will it take me? Who is going to look after my kids? You know, it is ok for the medical people and the government to push you around because they are in power. We are the “poor” immigrants that should be thankful that they let us in. In their eyes, they do not believe us. They think we are “pretending” to be doctors. We cannot be as good as them.

Still being very upset, she continued,

You would not believe how much I worry every day. Many times I just want to pack up and go back home, but I cannot. I just cannot. I am not strong enough to go back and face the situation there. It will be too shameful.

Dr. TFox said:

There is no recognition of qualifications once you arrive in Canada…they lie to you to get you to come here. […] I am here and I will find a way. I have to do it.

Dr. Vera responded to a similar probe about experience with the profession:

In my opinion, the people in the profession are just looking for excuses to keep out IMDs and this is why it is so sad for us. I acknowledge that some IMDs are good and some are not meant to be doctors, but that is no excuse to prejudge us. There are many different pre-screening ways to find that out early. Another thing, the profession does not have to have these elaborate foggy systems and processes to make people confused and send them crazy.

Have you ever seen the different stages to medical recertification for an IMD? I know some people who persevere and persevere until they get through, although it cost them a lot, and then there are others who keep trying and are not given a chance—like me. I am an example. […] I came to this country since 2007 to settle and have a family. I made no progress.

I also asked Dr. Flora if she would consider an alternative career in Canada if she does not get a license to practice medicine:

If I had known this is what they do to IMGs and make it so difficult to get a license, I would have prepared to do something else…It would be hard, though, because my kids were young, but medicine is my passion and I know I could make it work. I would have gone back to school for an alternative career when I first arrived in Canada. I was young enough when I immigrated, but after studying for the exams, writing them, passing them, and knowing that I am a good doctor, I invested a lot of money, time, and sacrifice in medicine all my life since arriving in Canada. If there was no need for doctors in Canada, I would have gone somewhere else, but it was always hopeful when you hear or read that Canada needs doctors and you know you are good. Then I decided to stick with what I know and do best, and that is what keeps me going…that is, medicine keeps me going.
think of it all day, how am I going to make it? What can I do next? I have to find a way or something.

Another participant, Dr. Arju, who I met at the Ontario International Medical Graduate School, said the fees for the school are not affordable, but he has to find a way to attend. This is the one way he can feel included in a group with doctors who talk the same language and are like-minded. He explained:

Since coming to Canada, I have not worked. I have been living with my brother here and he is supporting me while I try to prepare for the license. Yes, if I cannot get a license, I would like to do other work in Toronto but in medicine. I am very flexible. I can move anywhere where I can find a job in the medical field…I cannot give up medicine. It is part of me. My life is centered around medicine. If I cannot be a doctor, I will do research.

Dr. Arju explained that the need for more comparative clinical and scientific research between Canada and other countries in relation to diseases, behaviours, and medicines is great. He applied to both McMaster University and the U of T to do a master’s degree but has not been successful. He will continue to pursue this area of medicine. Dr. Artmad now responds to the kind of jobs he is willing to do in Canada:

I would work in any job related to medicine. I would work under the supervision of a Canadian doctor to gain Canadian experience, keep my mind alert, go back and open books and learn new skills. But so far, I have not been able to find any jobs in this area. But everything is not taken away... I will go through the process of everything the system wants from me here and I will do my best. If Canada does not want me, I will leave. I will take my Canadian experience and skills, and my wife and son, to somewhere else… If I had known earlier when I first came here, I would have gone back to school for an alternative career when I first arrived in Canada. After all these years, it is harder to change. I am sad.

I saw coming to Canada as the greatest dream to explore and advance in medicine with no limits as I have in my country but it is sad, too sad… I do not know how to explain it to you in words.

If IMDs were told before coming to Canada that “the stakes are high; it is a career-ending decision” as described by one faculty in an Ontario medical faculty (Thomson & Cohl, 2011, p. 3), many IMDs said they would have re-think their immigration to Canada or their plans for after arrival. While I worked at the medical school, I met an Ob/Gyn specialist from Vienna. Both he and his wife are from the Middle East. She is an anaesthesiologist and they are both practising medicine in Vienna. They received acceptance for immigration to Canada. Before
immigrating, he came to Toronto to check out the city, the hospitals, accommodation, social life, job prospects, and so on. He ended up at my office for Ob/Gyn residency programs for IMDs. After our conversation about Canada, job vacancies, and the application process for medical recertification, a few days later he returned to my office just before returning to Vienna. He thanked me for the information and said that after comparing his and his wife’s life and opportunities in Vienna as doctors and what it might be like in Canada and with the recertification process, he decided not to immigrate.

Thirteen of the 15 participants said they practiced medicine before coming to Canada. They worked in rural and urban areas. Giving up their medical practice, come to Canada and now facing such difficulties with medical recertification and getting any kind of work in the medical field, affect them acutely. Dr. Vera described her experience after she received her notification as:

The effects were subliminal (unconscious). All I wanted since I was a little girl was to be a doctor. I used to be more joyful and happy in the past when I was home working as doctor, but I wanted to learn more and work in a more highly recognized set-up with more resources and more opportunities to learn and stay excited. Now, it is different (seven years later). I do not get sleep, sometimes just wondering what I am going to do, how I am going to do, what kind of help can I get?

My mother can read me. She came to visit and one day she said to me ‘you say you are ok, but you are not the same person anymore. I do not feel you are ok.’ And I said, ‘because I did not achieve anything I want to since I come to this country.’ I know I can do more. I feel somehow the doors are not opening and I do not know what to do or how to find the opportunity. I tried for programs all across Canada but nobody is giving me a chance…Right now, I am doing research at a hospital. It is somewhat satisfying but it is not medicine. It is not emergency medicine. It is not taking care of the sick and seeing people survive life-threatening traumas and get better.

I also asked Dr. Maboo to talk about how being denied a chance to practice medicine in Canada has impacted his professional life. He responded:

There are so many different issues of patient care that need to be addressed and it is going to be a shift too late. Again, this is shocking to me. I tried hard to find out what is the problem when I was in Canada…I honestly, I didn’t expect it from the Canadian system to be this much faulty.

As an outsider looking in to Canada, you think everything is perfect. And when I came there and saw it, at first, I thought something was wrong with me, or I should do this or do that. But…I realize that Canada does not care about immigrant doctors… My personal
experience with the head of IMGs in a school in Western Canada, I did not know if he is still there now, he said after I went through the OSCE exam for one of the programs, that “you are a great diagnostician.” This was a word that I never heard of before. I said what does it mean? He said, “it means that you can diagnose a patient very good.” But because I failed to ask the scale of the pain at the OSCE with the patient, I failed the question, although I got the diagnosis right. When I asked him if I failed the whole OSCE because I did not mention the scale, his response was:

'This is the system we have and this system is not designed for you. It is designed for medical students and for Canadian medical students. It is crucial that the severity of pain is measured from 0–10. But for you as an experienced physician, yes, it is expectable not to ask that because you are not experienced with gauging the pain. But it is the system that they have.'

Yes, he was right, of course, but it does not mean that the whole system was like that. He was right and I was obviously very disappointed that he was not looking for immigrant physician like me. But this kind of rejection can have serious consequences on immigrants and immigrant doctors.

As I asked him to clarify what he meant by the above, he said:

I mean, as immigrants we should be grateful for the opportunity to be in Canada and leave a lot of [political unsafety] behind. And I would say, that most of the immigrants I met are trying to survive, but it is tough here…I have seen some people so crushed with despair that they had to take time away, with the support of their family, to go away and recollect and rejuvenate themselves. This was one reason why I said to myself, if I am going to do this, I have to do it fast or give up, just to avoid being crushed. I was not going to try for 5 or 10 years like others. It wasn’t worth the pain.

Five years later, Dr. Maboo returned to his home country to live.

Similarly, Dr. Eddie who has made several attempts and been denied recertification, said:

It was a crushing blow for me…

The exams are just exams. It is all basic knowledge with a few things that are more specific to Canada, but the exams were just exams about your knowledge and common sense. You just read it, cram it, and write the exam—you get what I mean? I do not know. Probably yes, probably no. They are wasting people’s time and ruining their lives…If they come out frankly and tell you are not fit to practice medicine in Canada, I would move forward. They list the guidelines and requirements, you meet them. You are called for an interview and you think this is your chance. Then you wait for CaRMS match day. It is a ton of bricks on your heart. This is my livelihood I am talking about. Then what do I tell my children?

A ton of bricks on my heart - this is how Dr. Eddie described the CaRMS Match date in Canada for him and for several thousands of IMDs who have met the requirements and denied.
Dr. Flora described how she suffered emotionally when she received the email notifying her that she was not matched. This was her sixth year in a row. She could not face her husband and her children. She was too hurt and embarrassed to speak to anyone. She practically went into hiding. For several months she did not contact the physician who gave her an observership and mentored her. She felt too ashamed and demoralized. Despite these experiences, these IMDs cannot easily give up medicine as a career. Too many people and children get hurt in their lives.

It is easy for stakeholders and others to say that IMDs should look for other jobs. As I have discussed earlier, IMDs wish they knew much earlier that they would be on a useless witch hunt. Rather, they are reminded that the licensure process is very competitive; they should keep writing the exams to increase their scores (International Medical Graduate Symposium, 2011). When they see IMDs are selected after 5–10 years of attempts, as in the case of Dr. Bashir (Hamilton Spectator, 2007), Dr. Salimi (Ontario International Medical Graduate School, 2016), and other IMDs they know, they become optimistic and keep trying for a chance and they feel that the rules are not rigid and anything is possible. Dr. Flora finds herself in this position. She thought she would eventually be selected. After six years of successful passing of the exams, invitations for interviews, and extensive financial and personal costs, she was once again shattered in devastation.

Like many IMDs, she is growing older and, after being in Canada for 5–10 years, does not have any career prospects ahead. At 40 and 50 years old, it is harder for IMDs who must now compete with younger CIMGs for the same retraining positions. Practising physicians in Canada could practise medicine beyond 70 years of age. Dr. Artmad calculated that if he is over 50, he has over 15 years to work and build his career and life in Canada. He lamented that if he knew earlier that there was no chance for a medical license, he would have planned his life differently. But at this stage, he has to keep trying or move to another city or country where he can work in the medical field (Dr. Artmad).

**Maintaining Professional Demure and Mental Health**

Dr. Salimi, an IMD who was finally successful in gaining a residency program at McMaster University after many years of trying, later opened the Ontario International Medical Graduate School specifically to help IMGs new to Canada. As the director of the school, and also course planner and lecturer, Dr. Salimi organizes and teaches courses to help IMGs prepare for
the Canadian exams. With his permission, I attended few of his lectures and OSCE sessions in the summer of 2013 while I was collecting my data.

I discovered that the “silent” reason IMDs pay high fees of over $2,000 for medical courses and mock exams (Ontario International Medical Graduate School, 2016) was to socialize, feel a sense of belonging, and maintain an affinity for medicine among medical professionals. Although they cannot help each other, they are facing the same challenges. Dr. Salimi’s course provides a collegial venue for them to share in a society of medical expertise and stay in the loop of medicine. They wanted to know that they are not alone in their journey for relicensure, but they are among others who can understand their pain that families and friends cannot fathom. They attend these courses also to show their family, and especially young children as Dr. Eddie, that they are doctors and are continuing to go to school and learn even at an older age. They do so to be role models for their children and communities, but the goal for IMDs is to learn up-to-date skills and obtain a license to work as doctors in Canada. Rather, Dr. Eddie said that attending the IMG School builds his confidence as a doctor even though he is not a doctor in Canada. It gives him a chance to continue to recognize their value, identity and self-worth as a doctor. Another person I chatted with at the IMG School said the course is refreshing. It helps reaffirm their sense of being a doctor. The instructor calls on students randomly to respond to cases from the textbook verbally and through OSCE practices in front of the class. She said being in such a learning environment forces a person like her, to engage, prepare for classes, and prove your medical knowledge. Another person said the course makes her feel like an “insider” among educated doctors. Being held in a university setting with “real-life” OSCE skill testing experiences with real doctors and standardized patients further fill the void to engage in medicine.

Attending the school provides a community for IMDs where they can take risks, forced to keep up with medicine, share their personal knowledge, and learn how to practice expert skills from an IMD who is in the system and who experienced their journey with medical recertification. Being led by Dr. Salimi is encouraging for IMDs. Although IMDs are foreigners and immigrants in eyes of the professional leaders, IMDs see themselves as medical doctors wanting to work in the medical field and make contributions to the country and society. While there are barriers to achieving their goals, they strive to find new ways to maintain their affiliation with medicine and maintain their pride in the profession by renewing their skills and
expanding their social support with like-minded people. Outside of the IMG School, such supportive networks are not offered for IMDs.

**Stress and Health after Denial**

Studies demonstrate that stress has a high negative impact on underemployed workers. It leads to impacts on mental health (Raykov, 2009), feelings of loss of control over their work, and deep emotional reactions associated with job insecurity (Kirsh, 2000; Livingstone & Sawchuk, 2004). While issues of stress and health came up frequently during the interviews, I found that the participants were very careful about how they articulated their feelings. For some, it felt safer to deny the stress or suffering cause from denial so as not to feel defeated. For example, Dr. Tila said:

Over the years, I managed to develop some strength to deal with it. I would never show them [my family] or anyone else how I feel or my weaknesses and frustration about this whole process. I tried to cover it by saying ‘it is ok and stay strong,’ but it is very frustrating and depressing. This last time (2013) when I did not get matched to CaRMS, it was the first time I cried in front of someone. None of my other family members know this. I cannot show my weakness, especially to my son.

One of three things that keep me afloat is the psychotherapy program. I think I could have “dipped” if not for it and [the other two things]. I was really feeling stressed and knew something was going to happen if I did not reach out! Of course, and like I said, people in my community, would not want to accept that they have such a problem and go for psychotherapy… It is very expensive ($3,000–$4,000/year part-time), but *I find it helpful.*

She continued:

There is such a need for it Cindy (speaking quietly), for psychotherapy, for counselling and mental health for people like us in the system. Unfortunately, there is such a stigma attached to it…it is not good to be seen *going to a therapist*…People think you are crazy or cannot handle life. It is horrible in some societies.

I asked Dr. Eddie how he manages work, family, and attending the IMG School since receiving denial for a retraining program. He said:

That is, of course, a very valid concern which I do have and questions everybody outside will certainly ask, but um, again, my strength has always given me the courage to be resilient and persistent in I want to get—all the way from when I was 17. I developed from a very young age good coping skills, so mentally I can work around it. But of
course, there are times when I feel depressed because I want things to go a little quicker... I try not to call it clinical depression [laughing]. I call it resilience, being resilient.

Another participant, Dr. Stella, referring to the same point about coping with life as a single parent and having no relatives and friends, said:

It is not that easy to be in this situation. I put up a brave front for my kids and I keep moving on. I do not want them to see me sad. At nights, I put them to bed but I cannot go to sleep. I lie there and wonder and think what can I do? Why did I do this? Why me? ...[pause and a long silence]... I am alone. I put the kids to bed and to avoid the bad thought, I get up and pretend to keep busy, to get tired so I can go to sleep. Sometimes, I would fall asleep in their bed with my street clothes...I do things aimlessly.

Sometimes I think I am going crazy, but I have to pull myself. I have responsibilities. I have my kids. I have to get up and go to work next day...we had everything we needed back home. We were very happy. If I didn’t push my husband to come to Canada we would still be there. I blame myself always…. I blame myself for pushing him… He is in some place and I am here. I would cry and cry and then fall asleep.

When I asked Dr. Enzo if he feels stressed having to balance two or three jobs now that his resources are depleted, with a family, preparing for the exams, and attending study groups, he responded by saying:

I am managing, but one of a very stressful point for me is not having the money and resources to be able to sit down, study, and concentrate on the exams. There is a group of people who are very much “disfavoured” at this point... A Canadian graduate writes the medical exams while having the opportunity to acquire a line of credit. ...The IMD comes to Canada with his family and all, and do not even know whom to reach in a new country. Imagine the stress we go through during this period! Is this situation healthy for me?

I am the man of the house and I have to work. One of us have to babysit our son. Because my wife cannot get her license either, she stays home and babysit. [...] it is hard for her and for me and it’s not good. We cannot do family things together. All I do is to care for this family to the point where I feel “exploited.”

IMDs come to Canada and expect to make sacrifices to obtain a medical license. They expect hardships. They know they will have to find ways to cope with the unexpectedness of being an immigrant in a new and foreign land. However, with many challenges and no direct answers to help them achieve a decent living in their new country, the pressure starts to affect them and eventually leads to weakened health (Reid, 2014). Reid argues that migrants, even with university education and other skills, will take any job when they first arrive in a country to gain
some financial independence, ease their resettlement, and wait for their credentials to be assessed. They survive with little effect on their health for about the first two years, but after about three and a half years, and assuming they have not found work in their field, their well-being starts to decline, and decline at a fast rate (Reid, 2012, p. 1).

In my sample of study participants, stress was highlighted as a major health issue. IMDs try to eat better foods to stay healthy and use good time management to avoid unnecessary stress at home, uphold their self-actualized self and goal, but the stress builds from feelings of fear and helplessness. As per the 2012 Mental Health Commission of Canada, mental health problems or illnesses is expected to cost the Canadian economy well over an excess of $50 billion per year (para. 1). One of the Commission’s strategic recommendations is to:

increase people’s understanding of how to recognize mental health problems and illnesses, how to get support if they need it, and how to get help for someone else (1.1.3)

If it is costing the government $50 billion per year now for mental health issues, it shudders to think of the increased cost if 6,000 IMDs accept their stress and depression as “clinical” depression and start to seek medical health. How much more will this add to the present cost for mental health care for IMDs?

Some participants put it that they feel like they are “locked up in jail” in Canada. First, if they leave the country, their eligibility for citizenship gets delayed. Second, they cannot seek work in other areas of medicine because they are qualified doctors and must follow the path to licensure and be licensed before they can engage in medical patient work. Third, going back to school to university to study medicine from the undergraduate is almost impossible. Who would support their education and their families?

Dr. Flora and Dr. Stella said that they felt like victims of a crime, but one thing the participants had in common was their refusal to identify or associate the stress in their lives with any form of “clinical” stress. Dr. Kripp and Dr. Maboo described their stress as “concerns” caused by the difficult situation they are in as foreign doctors in the country, while Dr. Stella saw it as the heartless and inhumane treatment of IMDs by the government and the medical profession.
When I asked Dr. Menita how she felt after being in Canada for six years and has not gained full understanding of the system or the requirements for a residency training position, she said, “Seriously? [chuckling]… Well, I do not know what to say. Pissed maybe?” She continued:

I never worked since I came to Canada. My husband owns his own business and he supports me. I look after our children and I study for the exams. Before each exam and interview, I studied…I dedicated myself and studied hard for the Canadian medical exams. [The residency program office] told me they use these scores to cut off applications. If they have 100 applications for one position, they did not interview everyone. They choose eight or 10 with the highest score.

Dr. McKenzie (2013) claims that immigrants, especially professionals who know they will never have opportunities to work in the medical profession again, live in hope that their children will become more successful than them. He determined this from speaking with a taxi driver in conversation, who told him that his career is over and there is nothing more he can do. Although he feels lucky to be in Canada, he will now work to support his children and encourage them to go to school. All he can do now is put his hopes in his children. But he also said that, if his children fail him, then Dr. McKenzie will see him as a patient at Canadian Addiction of Mental Health Centre.

This is another pattern among IMDs in Canada who are denied retraining. When they exhaust all attempts and unable to try anymore, they succumb to loss, put their hopes in their children, and hope that their children could make them proud. If not, the IMD might become a mental statistic from disappointment, as the taxi driver explained to Dr. McKenzie, at further financial burden on healthcare system and the government.

In 1988, it was estimated that $23 billion was spent on medical bills, disability, and sick leaves in Canada (Canadian Task Force, 1988; Globe and Mail, p. A4). In 2007, the federal government committed $10 million for two years and $15 million per year for two subsequent years up to 2010. This cost will also go up if IMDs start joining the list of patients who need mental health services, not to mention the added financial, personal, and social costs to families and friends of those with mental illness. Mental health illness, according to the World Health Organization (WHO), is a state of well-being in which individuals realize their own abilities. They can cope with the normal stresses of life, work productively, and contribute to their community (WHO, 2007). These are all things that IMDs would like to do, but cannot because of the stress and lack of opportunity in securing a decent life and employment.
It is crucial that the government and medical profession find ways of working with IMDs to help them achieve a decent lifestyle instead of driving them into mental health problems and ultimately to CAMH. There are too many restrictions on IMDs’ credentials, culture, and language. There are too many perceptions that IMDs are too deficient to engage in medical practice in Canada. As the guidelines and regulations continue to be blurred, and the intake of IMDs into the profession gets reduced, IMDs end up joining the gamble for a residency retraining spot at steep financial, emotional, and health costs.

Shuval and Bernstein (1997) argue that immigrant doctors who held valued positions in their home countries and are committed to their profession, will feel the psychological impact of losing their status (p. 12). For doctors who are at the height of their academic and professional achievement in life, almost any decline or change in occupation resulted in a decline of status (Shamir, Thoits, Warr, & Jackson, in Shuval & Bernstein, 1997, p. 12). This is what Dr. Kripp said about his experience as a doctor who immigrate to Canada:

The challenge is good…but there are times when I feel very depressed. I tried observerships at hospitals. They sent me to HealthForce Ontario [HFO]. HFO told me, sorry, they did not do that... I went to the Transition Program for IMGs, they want to teach me how to write a resume and hide my identity as a doctor. What am I going to do with a resume is the question? I am a medical doctor. There is one thing I know and that is medicine. Your mind is trained in such a way that you cannot just switch to something else easily. Some people may be able to, but this is not the case for the majority… Preferably, I will not give up working as a doctor. And when the chances are not there, it is very depressing.

**Language and Cultural Barriers**

IMDs are critiqued for having language and cultural barriers that affect their ability to communicate with patients and colleagues. These issues have gained significant attention from educators and leaders in postgraduate training programs as an impediment in retraining IMDs. However, most Ontario universities welcome Visa residents and clinical fellows from Saudi Arabia, the Middle East, and other countries with funding from their home countries for two-year to five-year training programs. Ironically, these residents and fellows with language and cultural barriers who are less interested in integrating into the Canadian medical system are considered a better fit for retraining programs than IMDs whose new homeland is Canada.

When I asked the participants about their ability to speak English and to communicate in the Canadian medical environment, their responses included:
Dr. Arju: I was born in Africa and immigrated to Toronto after completing high school in the Middle East, medical school in the Philippines, and practiced medicine in Africa... I see myself as “forever” an immigrant. I have no place to settle and no job. I speak very good English. I adapted to different cultures everywhere I go. That is not a problem for me. You can understand me, right?

Dr. Artmad: I will say, I am grateful to Canada. Canada has given me security and stability in life for me and my family but I want to have work someday. For work and a career, I am a foreigner.

Dr. Tila: I grew up in an African country so I spoke one of the West African languages as well. I studied in a Buddhist school...I am from a minority community in a West Asian country. There are only 50–60,000 people like me. I am from Indonesian decent in Sri Lanka. I speak and understand good English...I went to international schools where I studied in different settings from Chinese to Japanese to Portuguese in Nigeria. My parents were like ex-patriates who were brought to teach in Nigeria.

Dr. Tila is an IMD in Canada. She is an immigrant of colour. She is a foreigner with a foreign education. Her husband was born in Canada and studied engineering at U of T. He was a pilot for one of Canada’s biggest airlines. She flew to the West Indies every Sunday night to pursue her Doctor of Medicine and return home on Friday night to be with her young son. Even though she has lived in Canada for a long time, speaks fluent English, completed her internship electives in the US, she is a visible minority who falls within the three culprits for IMDs: Credentials, language and culture. Her husband, son and parents have waited a long time to see her become a doctor and they are still waiting. She said:

I tell my husband people automatically think that if you come from a country like India or your skin colour is different from White, you sort of live in “ghettos” (sorry I did not mean it in a derogatory way). They think people all live in “mud” houses.

These perceptions hurt IMDs as individuals, professionals, parents, members of extended families, and as persons seeking to integrate in the community.

**Sense of Self and Identity**

All but one participant had practiced medicine before arriving in Canada. They were eager to get back to work and ground themselves in their careers. Immigrant professionals tend to love their profession, and it is this sense of self that provides a “springboard for action” (Shuval & Bernstein, 1997). Professionals like IMDs feel that they must constantly reinforce and reconstruct their professional identity. They feel a profound need to re-establish a meaningful
sense of identity (Foster, 2008). Even if it means spending a large amount of money to travel long distances for interviews or observerships as Dr. Eddie, Dr. Kripp and others did, they will find a way to do it. As Dr. TFox said:

> Medicine is what shapes my identity as a man and a person and me as a professional. I am single. I only have to look after myself. I cannot stop being a doctor or working in the medical area. I will keep trying for a license... I have to do it.

**Personal/Family Impacts**

This section looks at the impacts IMDs experience in their families and communities after being denied a retraining program. Some of these effects have already surfaced in the discussion on professional impacts because of the interrelatedness of the individual as a doctor, spouse, parent, and role model. It is important to blend personal and family life because current studies and statistics show that many immigrants come to Canada as older professionals with families, and their children’s success is paramount to them (Boyd & Schellenberg, 2008; Statistics Canada, 2010; Livingstone, 2004; McKenzie, 2013; Reitz, 2001). Although the snowball sampling method I used for this study did not request information about age, gender, family, or marital status, they were included in the demographics sheet.

Only one of the participants had a job at a higher rank that pays over $70,000 a year. This was possible because she had a plan B when she arrived in Canada. She completed a Master’s degree in Public Health and was able to find a job using her master’s degree. All the other participants who disclosed information about their work had low-wage salaries or were unemployed. Dr. Gerty for example, works as a lab technician:

> My salary is low. The job is also routine, 9 to 5, or different hours. It is not the same satisfaction seeing real patients and helping them and my husband knows that I am not happy. My husband wants me to be happy and tries to encourage all the time, but I feel so pushed that I am so tired now, working, taking care of the children and looking after the home, but I cannot stop. My husband says I have to keep going... because this is the only way I can reach my goal and I want to reach my goal.

When I asked if the pressure from her husband bothers her, she responded “yes” and continued:

> I feel pressured for family reasons. My children are growing. I would like for their sake to become a doctor here and work as a doctor, but it is a lot of pressure for myself. And my husband also pressures me a lot... I always think of the exams and what I can do to be a doctor. It is always on my mind night and day. I cannot remove it. I cannot get too involved in other things because of this pressure...this is my goal. I have to reach it.
I try to show a ‘happy’ disposition, but deep down inside, I am tired now. I and scared that I will let him down and my children. How can I tell my children to do well in school if I myself am a failure?

Dr. Flora responded similarly to the same question:

My husband showers me with the big hope that one day I will get the job because it is affecting him too. He is struggling. He is self-employed. It is very hard to do business here is Canada, so he also becomes frustrated… I practiced medicine more than seven years before coming to Canada. I immigrated here for a brighter future for myself and my kids, to live in a more peaceful, democratic and westernized country where there are more opportunities for my children… because there is a shortage of doctors in Canada, I thought it would not be difficult to get a license to continue to practice medicine here.

Dr. Enzo, whose spouse is also a medical professional but has put her career on hold to bring up their son and do some part-time jobs while he secures his medical license, said the following:

I work several jobs to pay for exams and to support my family. That is what the man as the doctor does in my country. If you do not work here in Canada, you would not have any money. You cannot survive in Canada without money… My wife is also a professional who is not licensed… We both shared the childcare responsibilities for a while. Imagine [said emphatically]… two professionals reduced to babysitters?…

Dr. Vera, who is married and does not have children, explained that she and her husband were very excited when they received their visas to immigrate to Canada. Their family and friends were very happy for them and celebrated with them as they were leaving for a better life in Canada. She said:

I was a leading doctor in medicine in my hometown and everyone knew me and respected me as their doctor. […] I had this great vision for emergency medicine and they all knew I was coming to Canada to be a great emergency medicine doctor and save lives.

In my country, there is a respect for doctors…and more respected when you leave and go abroad. I will be laughed at if I go back home now. This is very demoralizing. I cannot go back home and I have never gone back home since I came to Canada… I would not go back home.

When I asked how her personal life has been impacted since being denied retraining not only once, but more than once, she laughed and said:

Humiliation and fear. Fear [with emphasis], what am I going to do. I will lose everything… Now they are asking for recent clinical experience and nobody will give you the experience here. They think I can just go home and get it.
I used to be more joyful, happy in the past. Now (seven years later), it is different. I do not get sleep sometimes just wondering what I am going to do, how I am going to do, what kind of help can I get...I applied to the Nova Scotia and other programs...If I get accepted, I will move from Ontario completely. I want to study emergency medicine and Toronto is the place to do that—St. Michael’s Hospital, Sunnybrook. You cannot ask for better experience and it will not be the same in, say, Nova Scotia. I will go if it means that is the only way I can work in medicine.

**Personal Identity**

Historically, the image and identity of medical doctors is one of status, prestige, elitism, power, and respect (Blishen, 1968; Naylor, 1986). The indoctrination doctors receive during training instills a lifelong attitude of pride and privilege. This identity can have a significant influence on an IMD’s career development, values, and personal, family, and social life. It is common for parents who are doctors to want to pass their values of care giving and compassion for the sick down to their children. As Clausen (1991) and Gomez, Fassinger, Prosser, Cooke, and Mejia (2001) argue, a person’s identity strongly influences the type of career that he or she seeks out. Moreover, balancing the multiple roles of professional, parent, spouse, role model, and family member often intertwines with layers of self-concept of identity beliefs (Gomez et al., 2001). It is not surprising that IMDs’ persistence in holding onto their professional career, individuality, identity, and family life can lead to added burdens and marital problems in the home.

**Family/Marital Problems and Loneliness**

Dr. Enzo sent me an email after our interview saying:

I opted to write you those lines as I had an argument at home that left me a bit distracted. I was told I am a student all my life; this is what medicine is. You have to study all your life, and I am such a person—devoted to my profession. Loneliness in a home can be derived from when the spouse is away at work or studying day and night. It can be when children are involved and never see a parent.

This absence can lead to much bigger marital problems within IMD families. Dr. Enzo work, studies for the exams, and tries to keep up with medicine. He absorbs about 10 to 12 hours at a time for months on end. He started to encounter “lots of headaches [problems] at work” as he tries to hold on to his job. Coming home late at night after a long day at work and studying after work can cause many problems at home. He is tired by the time he gets home, but the family needs him. His presence is missed. People tell him that he spends all his life studying and “that’s
what medicine did to him.” It hurts him to hear this. “Even if you are the provider in the home, you work and pay the rent, and pay for food and everything else, that is still not good for a family.” He indicated the sadness he feels and how tired and stressed he has been, and rhetorically asked if I can imagine “what is done to healthy children that soon become unhealthy after growing up in such a family as mine where all I do is work and study and never even can spare time to celebrate my son’s birthday?” He continued:

Imagine the impact that somebody, especially being a husband, a father, has at this moment, not being able to provide for his children and family, not being able to sit without stress about writing a test or an exam.

Another participant, Dr. Flora, said she was very scared of her husband’s reaction when he found out that she did not receive an interview again. She did not know how to break the news to him. It is not that there is no love and they don’t work together. The exams cost a lot of money. He kept telling her all year to study hard and that she must make it into medicine this year. When she found out she was not granted an interview, she was “in shock … terrified, devastated, and frustrated.” She wasted so much of the family money again when they were trying to save up to buy a house. She said she “wanted to disappear and never see him again.” She continued:

My exam result scores were high. I went through interviews in the past and had an idea of the kinds of questions they would ask. I had good observership experience with a doctor at a major teaching hospital.

She also indicated that, this time, she was very confident about getting an offer, but when the CaRMS match was released, her worst fear came true. Scared and ashamed, she avoided her husband. But after two days, she finally told him. They were both upset and started to hurl remarks and insults back and forth. They did not speak with each other for several days. She said this was the first time in their life together that they did not speak to each other. She knew that this behaviour was not good for their children. She did not know what to tell them: “How can I tell my children that mommy and daddy are quarreling because mommy failed and cannot be a doctor? What will that do to them for the rest of their lives if they saw us reacting to failure as we did?” She continued:

There is something about becoming a doctor in a country where women were not privileged to attend university. You had to be strong. Failing was not in the vocabulary, you just had to be successful. Coming to this country and failing is hard for any
immigrant and worse for an IMD like me and a female. As a female, you feel that you must continually prove yourself to families and communities and show them that you are worthy of higher education. This is not easy to do and I am getting tired. I did not know how long I can continue like this.

**Family/Spouse Unity**

Family reunification has been a pillar of Canadian immigration since the Citizenship and Immigration Canada Act of 1984. This policy is to be applauded, but the Canadian medical profession compromises it by creating problems in the lives of IMDs and their families. As shown previously, parents are choosing to live apart from their families to hold onto their sense of self and self-actualization, while creatively revolving their needs around the goal of medical recertification. Their children’s lives are compromised because one parent is always out working, doing observerships, studying for exams, or writing exams. Ironically, the families that are splitting up immigrated under the Federal Skills Workers Program (Services Canada, 2013) as economic class workers to fill job vacancies in Canada. While opportunities to work in their profession cease, family splits, marital problems, and loneliness take hold (see Table 4). Findings from the study reveal that:

- Four of the male IMDs expressed thanks to their wives for taking responsibility for the children and being a good parent on both their part.
- Three of the four spouses of the male IMDs are working in non-professional jobs to financially support the family and raise the children, rather than pursuing their own licenses to practice medicine in Canada.
- The wife of one of the IMDs is continuing her medical career in another country on the agreement of the family so at least one parent can retain professional status.
- Two husbands of the female IMDs are in accounting and secured jobs in their fields. They are supportive of their spouse pursuing a medical license in Canada.
- One spouse is a retired pilot for a major Canadian airline and is currently teaching his specialty at a Toronto community college.
- The other four spouses of the female IMD participants are small business owners and entrepreneurs.
- One female IMD works at a coffee shop and cares for her two children while her husband pursues re-licensure in another town in Ontario.

These kinds of marital relationships do not help the family. They do not uphold Canada’s reunification policy. But IMDs persevere. As Dr. Eddie, they have to be resilient and not get
swayed by clinical depression but look at it as “coping” in life’s journey. Many take a gamble, and risk poor health, stress, and marital problems. They do not give up.

**The “Given-Up” IMD**

I indicated earlier that one of the limitations of the study sample is the lack of interviews with IMDs who have completely given up on medical recertification. This was not from lack of trying to reach these IMDs. It was difficult to convince them to participate in the study. In two cases, the participants did not wish to be interviewed. Dr. Male (pseudonym) is a physician whose son is a security guard at a university. In conversation, the son told me his dad is an IMD. The second is Dr. Female (pseudonym), a physician I met through another IMD.

Dr. Male’s son gave me his father’s contact number. I called him. He was interested in the study and willing to participate. He has a circle of friends who are also doctors. They meet at the coffee shop every day. Dr. Male was the oldest in the group. He is married and has three children. The son I spoke with is the eldest, and there are two daughters. From the beginning of our conversation, Dr. Male expressed bitterness and unfairness about the medical system because he practiced medicine all his life back home and cannot work in Canada in any area of medicine. He was unemployed. One night when I called, his daughter told me he was sick. They had just brought him back from the hospital emergency, and he was resting. She explained how fed up he was about finding work in his field, and that the hopelessness is “killing” him. He needs something to do. He needs to work and be valuable to society to boost his ego among family and friends. Two days later, I called again. He was home. We spoke and set up a time for an interview the following week at his local coffee shop. It was the Mother’s Day weekend.

He took the time to explain his wife’s business to me. She makes special occasion flower baskets. She was busy, and he was happy to help her. She was a nurse back home and taught at the university, and neither of them are working in their profession. On the day of the interview, I called several times to confirm our arrangements, but no one answered the phone. Hours later, I finally reached his youngest daughter who said he was sleeping. They just brought him home from the hospital. We decided to postpone the interview.

Dr. Female physician (Dr. Female) also agreed to an interview but cancelled out at the last minute. She lives in the west end. She works two part-time jobs. She has children and lives at home with her family. Her life is busy with the jobs and her family, and we could not fit in a
time to meet. We agreed on a telephone meeting, but it had to be at a time when her husband and children were not at home or not in the vicinity where they could overhear her conversation. She was too embarrassed to talk when they were around. We tried for a few weeks to set up a time. We chatted a few times briefly, but there was never a good time within several weeks to have an interview. She was busy during the day at work. In the evening, she was busy with the family. She also did not want to conduct the interview from home for her husband or children to hear. To them, it might translate that she was complaining about the profession. I would have liked to hear her story to hear her perspective. She offers her word that she will help in any other future endeavour relating to the IMD cause.

**Social Impacts**

Hotchkiss and Borow (1996) demonstrate that social, economic, and cultural factors can facilitate or hinder an individual’s career development. These factors include the structure of the labour market, race and gender, education, family, and socio-economic status. Their “common status attainment theory” is based on “the social status of one’s parents” and how this affects the level of schooling and occupation achieved (p. 285). The general norm shows that “individuals who are from middle-class and upper middle-class families are much better off in terms of achieving an occupational level compatible with their families’ socio-economic status (Barbera, 2013; Chen, 1999). At the same time, the authors recognize the influential and sometimes determining effect of chance. The chance factor can enable people to exercise control over their life and career. While some chance factors, described by some theorists in sociology as the accident theory (Minor, as cited in Chen, 1999), may be predictable to some people, it may not be as predictable for others. How do IMDs fit in here?

We cannot say that IMDs in Canada fit the general norm described by Chen (1999). For the past 20–30 years, the IMDs coming to Canada, come from a higher social and economic status than the average person who has no access to education or professional jobs. Yet, majority of these IMDs end up falling into a poverty level life-style as evidenced in this study and other literature. I did not ask participants specifically about their socio-economic status, but as evident in the interview excerpts, participants talked about their middle-upper class lifestyle and access to good schools and education. These were not accessible to lower and poor class people in most developing countries. Participants with children, in most cases, talked about their children or
children and better opportunities for schooling for their children in Canada. Dr. Stella, for example, said: “I will sacrifice my own happiness to ensure that my children become successful and get a good education and eventually a good job in this country.”

Shuval and Bernstein (1997) also point that when a social role is valued because of its high salience to the individual and its high status in culture and society, a person is likely to resist or resent abandoning it for other work (p. 12). For IMDs, earning a Doctor of Medicine degree is a symbol of high status. Diminishing that status by accepting work in the non-professional and unskilled labour force is not comforting for IMDs. Since they have no control over whether to keep or reject their professional occupation, they wait for a reinstatement with no guarantee that it will happen.
Chapter 9  
Re-imagining Change

Of all the forms of inequality, injustice in health is the most shocking and inhumane.

Martin Luther King, Jr. (Bohan, 2014, para. 1)

IMDs educated and trained outside of the US, Australia, New Zealand and other former British colonies are deemed as un-equivalent for the Canadian medical system. The emphasis on credentials, lacking empirical reference, to the actual training and certification of IMDs continues to mirror larger distinctions made in the governance of the British Empire from the early 20th century onwards (conversations with Olson, December 2016). When the British consulted with New Zealand, Canada, South Africa, and Australia as “mature” members of the Empire on incidents after the First World War, other smaller developing British colonies were not included in the consultation process. With reference to conversations with Olson (2016), this reflects the political and demographic presence of British elites in countries whose demographics were overwhelmingly of White British descent. Olson reminded me that until 1977, a citizen of Britain did not need to make application to enter Canada while citizens from other countries in the British Empire were required to do so. The implied logic was that Canada was an extension of Britain and British institutions, including the institution of medicine, persisted to fall under the British influence even though the patient population is no longer mono cultural (Olson, December 8, 2016).

Ontario’s communities and patients have expanded vastly from a homogeneous to non-homogeneous and multi-diverse population, primarily due to Canada’s non-discriminatory immigration policy (Whittaker, 1999). All lives (natives and immigrants) matter and are accounted for in the Canada’s democratic and just society and by the government. To prolong inadequate healthcare services to patients in ethnic, native and underserviced communities does not only contravene the government’s commitment to these people, but also leads to unequal and unjust access to care, which, quoting Dr. Martin Luther King, “of all the forms of inequality, injustice in health is the most shocking and inhumane” (Bohan, 2014, Para. 1). It is also a deliberate waste of skills and an unjust waste of human potentials to have thousands of educated and trained immigrant doctors willing to serve the needs but cannot do so because adequate mechanisms are not in place to adequately capitalize on these doctors’ skills to meet the needs of
patients. This chapter, therefore, lays the groundwork and explores various options for reassessing IMDs’ skills as potential assets in the delivery of healthcare. I make suggestions for reconsidering IMDs’ skills in the recertification process and to develop new plans to identify IMDs’ skills to match skills to the needs of patients through a Diversity in Medicine (DIM) program. I suggest a Moratorium for the IMDs who have actively sought medical recertification, gained additional Canadian medical knowledge, but are barred from accessing the profession and caring for the sick. Moreover, I provide discussions to establish a separate office to manage IMDs’ transitioning to recertification and other medical workforce in Ontario. This office would handle the backlog of IMDs who have been seeking medical recertification since 2003 to 2013 through a vision for change.

**A Vision for Change**

Albert Einstein is quoted as saying “we cannot solve our problems with the same thinking we used when we created them” (BrainyQuote, n.d.). “If we want to change the world we have to change our thinking…no problem can be solved from the same consciousness that created it” (AZ Quotes, n.d.). Kurt Lewin’s (1946), a researcher and sociologist at Cornell University and a refugee scholar who fled the Nazi regime, first developed his theory of action research for change when he experimented with a visible minority problem against Jews in Cleveland, Ohio. He became aware of the problem which others have tried to resolve for many years and were not successful (Lewin, 1946). After studying the problem of the group of minority Jews in the early 1940s, he applied a common sense and practical approach to strategize and work through it. He reached out to people in the communities and in the community offices. He reached out leaders of organizations, stakeholders and others whom he felt might be valuable in solving the problem. Using a step-by-step iterative process as depicted in Figure 18, he solved the problem. His problem-solving research methodology started to gain popularity and has continued to be used by researchers and organizations up to today. Carol Weiss (1995), a Harvard School graduate and a prominent educator and evaluator, argues that replication and evaluation are important in designing small or large programs for change. She hypothesizes that one of the key reasons complex programs can be difficult to evaluate is because the assumptions inspiring them are poorly articulated (ActKnowledge, n.d.; Weiss, 1995).
Weiss (1995) argues that stakeholders of complex community initiatives are often unclear about how the change process unfolds. They tend to put little attention on the early and mid-term changes, thus making the move to long-term goals harder (ActKnowledge, n.d.). Sometimes, clarity about what needs to change or how to change it to reach a long-term outcome can be difficult and challenging. Weiss’s theory of change is a specific methodology used mostly in the not-for-profit and government sectors. It involves ongoing participation with stakeholders throughout the process for change to be possible. Weiss also popularized the term “theory of change” as a way of describing how a project evolves and how it is accomplished through constant monitoring and evaluation at each step of the way (ActKnowledge, n.d., p. 1). She calls for a common-sense approach in solving problems and making change, similar to Lewin’s model. Since the publication of Weiss’s (1995) book, the use of her theory to plan and evaluate change has increased exponentially among philanthropic societies, government agencies, international NGOs, the UN, and many other major organizations in both developed and developing countries. Lewin’s (1946) and Weiss’ (1995) have led to new areas of work, such as linking the theory of change approach to systems thinking and complexity. Weiss argues that change processes are not linear, but have many feedback loops that need to be understood. Theories of change entail improved monitoring, evaluation, and learning. They are also helpful
to understand and assess impact in hard-to-measure areas such as governance, capacity strengthening, and institutional development.

This brings me to reflection of my own findings in this study and how I can incorporate immediate and long-term goals in monitoring and evaluation to initiate change in the IMD situation. I bring together Lewin (1946) and Weiss’ (1995) plan of action and theory for change as a framework to re-imagine, what I see, as a new vision for IMDs under a new IMD Office and the DIM program I proposed in Chapter 10. Re-imagining a model to capitalize on IMDs’ skills with stakeholders, leaders and persons directly involved in the issue with IMDs, to “buy” into developing a practical plan for change in resolving the IMD problem, is timely. At the “Confidence Building and You” forum I organized for IMDs in September 2015 (Appendix L) where over 50 IMDs from across the GTA were in attendance, almost every attendee raised their hands in response to change in the medical recertification evaluation process. They are willing to work as licensed physicians as well as assistants to physicians. They are willing to work in other alternative jobs in medical field. Medicine and caring for patients is what they have studied and practised all their lives. This is what they came to Canada to do. They want to work in the medical field and contribute their knowledge and skills to care for patients. Rather, many participants in this study also indicated they would welcome opportunities to work in areas in the medical field in hospitals, doctors’ offices, clinics or wherever the needs exist, in order to gain experience for their CaRMS application or contribute to the profession in other ways and earn a salary.

Participants of the study expressed their willingness to relocate to underserviced areas in Ontario and other provinces in Canada where the needs exist. Dr. Kripp and Dr. Arju said, they are willing to take more pragmatic approaches in their career path in Canada. Dr. Kripp has been exploring insurance medicine. Dr. Arju has been applying for master’s degree programs in health science research and methodology and said, he has transferable skills. Even though he is still waiting for acceptance of a retraining residency position, he would keep exploring the possibilities for medical and scientific research on international medicine.

IMDs are ready and willing to think of their career in a broader context of medicine. I believe the timing is right to explore new ways of capitalizing on IMDs skills and talents to benefit the profession and the Canadian society and economy. I believe this is possible with the
establishment of a special IMD Office which would be designed to provide a one-stop, one-on-one assistance to IMDs, to facilitate advising and preparation for medical recertification and other medical career in a timely manner. Applying Lewin’s (1946) and Weiss’s theory of change approach (1995) of looking at the problem from a more practical and common-sense approach, with stakeholders and iterative planning, will be a good starting point.

The government supported the former CEHPEA and current Healthforce Ontario offices to provide support to health professionals educated abroad. However, as participants have said, these offices are not always up to date with information change or available to IMDs. The guidelines and information for medical certification change frequently or are unclear and adds undue financial and personal burdens to IMDs. Because IMDs see the process as their only chance to gain medical certification, they continue to keep their application process active, even if it means taking a gamble with the odds against them (see Chapter 7). Re-imagining new possibilities with a plan for change to reduce the backlog of IMDs who are caught in constant denials of retraining even though qualified and need for doctors, but continue to persist for a chance to capitalize on skills for livelihood in the medical field, is long overdue.

Researchers have recognized the influential effect of chance as giving people the opportunity to exercise control over their life and career (Minor, cited in Chen, 1999). Since IMDs tend to be self-actualized individuals with optimal goals to work in the field of medicine, the DIM program I am proposing would provide an avenue to tap into IMDs’ foreign skills and their combined years of informal learning and new medical education knowledge gained from studying and passing the exams. Moreover, this combination of foreign and Canadian medical knowledge IMDs possess is a unique and untapped resource of skills which can be valuable to the new realities emerging in patientcare in Ontario’s diverse communities. These resources should not be left untapped. An IMD Office with qualified and knowledgeable personnel and a DIM program, would provide valuable and timely assistance to IMDs. It will help IMDs with understanding the medical recertification requirements and processes, and with alternative medical jobs and new career trajectories.

As discussed in this study, the recertification process for IMDs has multiple layers and barriers. It is a very protected and complex process. There are many centralized web-based information sources available to IMDs, such as CaRMS, physician.apply, RCPSC, CFPC, MCC,
Healthforce Ontario, OFC and University programs. These resources are mostly written in English or French. Ironically, while the profession labels IMDs as deficient in language and communication skills, and unable to engage in retraining and practice of medicine in Canada, the onus is on IMDs to interpret, understand and follow the rules. As we see, this is not simple to follow. An IMD Office, however, would have the responsibility to provide information and personal assistance to IMDs. It would align with Canada’s immigration ministry and the various professional stakeholders of the profession, as well as community stakeholders and representatives, to better manage the advertisements, recruitment, re-licensure and transitioning of IMDs into professional careers. The IMD office is expected to also have the responsibility to align with other stakeholders in ensuring immigration policies are aligned with the human resource planning and retraining of foreign doctors in Canada. The Office will help to curb future waste of international human capital and skills while assisting IMDs with professional career transitioning in a timely fashion.

Applying an iterative step-by-step process (Figure 18) of reflection, planning, generating ideas, consulting with stakeholders, and drafting a plan to solve a problem would be the first step in envisioning and planning for the IMD Office. Lewin did not stop with his initial plan. He spent time re-reflecting, observing, re-exploring and re-engaging with everyone. He spent time re-evaluating the plan and repeating the process, keeping in mind, the broader spectrum to involve all the relative stakeholders in discussing the plan and develop a plan for action that involved all stakeholders to buy into it for best results. Gabel’s (1995) also suggests involving different stakeholders in developing a plan for change. For example, he suggests involving teachers in the case of the teaching profession, who might know more about the subject of teaching. He feels people with skills might just be waiting in the wing to be invited to participate and contribute to research studies (para. 1), a similar experience Lewin encountered (1946). As well, Kemmis’s (199) cyclical four-step action research model (Figure 19), which allows planners and visionary thinkers to draft up an initial plan, then take action, observe, reflect, and continue this format in a cyclical motion to develop a plan to take action, would guide the action for change in the proposed recommendations in this study.
If a group of people can become involved in identifying a problem and work towards a plan to resolve the problem, this joint effort can lead to better success argues O’Brien (1998). If they are not successful in the first attempt, reflect, replan, react, observe, and continue the process until the problem can be solved, using Lewin’s (Figure 18) and Kemmis’ (Figure 19) models, until everyone can be satisfied, would lead to action for change. Using this kind of assumption, Lewin experienced this by putting himself in the position of the racialized minority Jewish people in a dominant society in Ohio. Through observation, Lewin observed the inequalities the Jews faced as minority immigrants in the community. His experience was that people in the institutions and organizations that seemed to be responsible for the problem were ready and willing to speak and work with him to understand and work with the problem.

**Refocusing of Study**

As mentioned earlier, I did not initially plan to take the route of action research in this study. However, the data is compelling. The impacts of the denial of recertification on IMDs’ lives from a historical, anti-colonial, motivational, and economic perspectives are compelling. Considering suggestions from committee members, Professors Peter Sawchuk and Paul Olson, I was prompted to revisit my plan. Embracing Lewin’s practical approach to solve a minority
problem makes better sense. It makes sense because IMDs have faced systemic discrimination and stigmatization as immigrants (Borges, 2011; Guo, 2009, Li, 2000). Their credentials, culture and language that have marked IMDs as unsuitable for retraining to practice medicine (Zulla, et al, 2008) continue for decades even though patient demographics are becoming more foreign and match the skills of IMDs. IMDs who possess the skills needed for growing ethnic patients are still deemed unsuitable to fill the doctor shortage gap. It also makes sense because the U of T BPAS 2013 report, determined by an exclusive group of top-management leaders, suggests further traditional style assessments and evaluations of IMDs but did not take into consideration new ways to re-examine IMDs’ skills for future patient care needs. Tepper’s (2015) argument that doctors need to serve communities and have a commitment to equity, helps to further support my plan to proceed with a new model to capitalize on IMDs and their human capital to serve communities, as well as gaining access to the workforce.

Reflecting on the CaRMS match result from 2011 to 2016 where a total of 15,784 CMGs were matched to R1 programs in the residency match, only 2,564 IMGs were matched (R-1 Main Residency Match, 2016). If, as estimated, that 33% of the IMG positions go to IMDs (CAPER, 2013), then we can assume that 33% of 2,564 matched IMGs = 846 of IMDs matched to retraining programs between 2011-2016. This low inclusion of IMDs does not represent diversity of ethnic representation of doctors in the profession. It does not reflect integration or transitioning IMDs into professional careers. It does not reflect fairness of IMDs that 94% are poor and incapable to continue their medical career. Rather, it reflects a costly waste of human capital at a time when there is a staggering low supply and high demand for doctors that leaves millions of vulnerable patients at high life and death risks, and thousands of IMDs facing the brutal termination of their life-long professional career. Thus, refocusing this study to explore practical options using Lewin’s (1946) model for action research makes sense. It makes sense especially from a sociological and social justice perspective despite criticisms of Lewin’s model. Following is a discussion of criticism of Lewin’s model in light of support to this study.

Critiques of Lewin’s Model

Although Lewin’s iterative model for change has gained wide support in the research community since the 1940s, critics such as Longo and Kanter, et al in Longo (2011) argue that Lewin’s approach was too linear and static in design and too general and simplistic. Lewin’s
model has been criticized for advocating a top-down and overly management-driven approach to change. It has been criticized for not being reflective of changes that were occurring in the business environment where things do not stay the same for long time and where support for change may not be forthcoming from staff and other members of the organization (Longo, 2011). However, as Lewin maintained, change is a process. It is a transition that involves people (Lewin, 1946). Change is not an event. It must take careful planning. It must involve good communication among stakeholders. Fears and concerns about how the change may affect individuals’ jobs and other employment conditions may occur, but success with change, as Porter, et al in Longo (2011) argue, requires good counterbalancing acts to ensure success.

Others criticize Lewin’s three-stages of Unfreeze, Change, Freeze, as being too simple to introduce change (Longo, 2011). However, sixty years later, at a time when tremendous changes are taking place in the world through technology, transnationalism, globalization, migration, and immigration, Lewin’s approach for change model continues to follow a simple plan and continues to be respected by organizations as a relevant for change. Businesses continue to use Lewin’s action research for change model to work collaboratively with stakeholders, to plan, design, and implement change in the business sector (Longo, 2011). Medicine on the other hand, tends to still prefer to focus on assessment and evaluation of skills and lesser on learning by doing (O’Brien, 1998). Rather, as Shneider (1987) argues, these kinds of assessment and selection processes only tend to perpetuate sameness. That is, they lean toward choosing people to work in an organization who are like those already in the organization, thus restricting others who are not of the same color and stripes from accessing the organization.

For the past four decades since visible minority IMDs start coming to Canada as a result of Canada’s non-discriminatory immigration policy (Whittaker, 1999), consistent forms of evaluating exams, interviews, OSCEs, and the more recent BPAS (U of T BPAS, 2013) have been implemented to assess and determine IMDs suitability to fit in the profession. Significant costly efforts by the government and the stakeholders of the profession to improve the exams, tests, and assessments of IMDs have taken place. However, the evidence of choosing different exploratory methods to re-assess and re-think IMDs’ personal and international skills as contributions to medicine still seems faint. This brings me to my model for the DIM program (Figure 20) and a non-homogeneous plan for change (Figure 21) in the context of IMDs and the medical profession.
Depicted in the proposed charting for a DIM program (Figure 20), which requires further enhancement by experts, I place IMDs at the centre of the DIM program. In Chapter 6, I discussed how the self-actualized attitudes and believes in themselves, lead IMDs to a passion and belief that they can care for patients in the Canadian medical system. The DIM program focuses on keeping the goal of IMDs in mind and, from there, extracting and assessing their skills for contributing to patient care.

**Figure 20.** Blueprint for a Diversity in Medicine Program.

This model suggests a plan for developing, organizing, and managing a program that determines the skills and talents of IMDs, and the need for such skills in community medical offices, clinics, community centres, hospitals, and academic institutions. Understanding how to utilize IMDs’ competencies of language, culture, understanding of foreign cultural signs and symptoms, expressions of patients, verbal and non-verbal communication, and various diseases
is at the centre of the model. After that, it is important to establish the desired vision/mission, goal/objectives needed to reach the goal. Once the goal is identified, the next step is to reach out to external and internal sources to collect data from IMDs in the form of the competencies they possess. These sources would include organizations such as CaRMS, physiciansapply.ca, and the Medical Council of Canada which already have information on IMDs through their registration for medical recertification in Canada. In addition, the proposed IMD office would be responsible for compiling a list of the competencies IMDs possess and the needs of patients and doctors practising in various communities. This would then be incorporated into a proposal to the Ontario government and other professional organizations for funding. Concurrently, the DIM program leaders will reach out to physicians in the GTA to discuss the possibility of hiring IMDs in their practices for a salary, which will also be included in the funding proposal.

The leadership of the DIM program will bring recognition to the proposed DIM program. The leadership will reach out, invite, sell, cajole, inform, and convince representatives and stakeholders in the medical profession and the government of the need for such plan for change and its vision, mission, and goals for the program. The aim would be to follow Weiss’s (1995) advice first, to decide exactly what the leaders and supporters of this program really want to achieve, how they can tailor their plan to achieve the goals, and how to evaluate the program (Weiss, 1972) for ongoing effectiveness, transparency, and accountability. This is indicated in the right oval of the DIM Program Blueprint (Figure 20). Referring to Lewin’s four-step iterative model, strategizing, prioritizing, and motivating others to buy into the program would be crucial.

**Non-Homogeneous Model for Change and Benefits**

In the history of the medical profession, there has been a shift from a homogeneous white patient population to a non-homogeneous diverse population caused primarily from Canada’s non-discriminatory immigration policy. With this policy, no one is denied entrance to Canada because of their race, color, religion, country of origin or sex. Immigrants and refugees are welcomed from all corners of the world and meet up in the GTA and other big cities in Canada, thereby changing the patient demographics to an increasingly diverse patient population as discussed earlier. The non-homogenous model of change as depicted in Figure 21, provides a charting to allow for identifying the specific skills and competencies IMDs possess in various areas, much broader than what is listed in the center of the figure and to design best-fit of IMDs’
skills to patients’ needs. This model would benefit and motivate IMDs by providing them opportunities to work in the medical fields with doctors and to learn or supervised by them. It is designed with the goal to motivate, empower and help increase the confidence, satisfaction and well-being of IMDs, while they gain first hand experience in the medical workplace. It is expected to provide improved access of care to patients in their local communities. For example, the different languages IMDs speak; the variety of culture and religious backgrounds, primary care and other specialty experiences IMDs possess, might enable them to be interpreters, advocates, counsels, support and provide care to patients, which are valuable skills needed by patients and societies in Ontario. IMDs’ competencies could also include scientific, research

**Figure 21.** Non-homogeneous model for change.

...and clinical trials from a multi-disciplinary and global perspective. They could include expertise in teaching and facilitating intercultural education and understanding at faculty development and...
at resident academic seminars in postgraduate education. From this experience, IMDs could be role models to their families and younger students in communities and their work office.

Taking the needs expressed by patients in works by Asanin & Wilson, 2008; Esmail, 2011 and Coloma et al, 2013, would be a starting point for developing a bank of patients’ needs. Collecting similar data from doctors’ offices in the communities and hospitals across the GTA would add to this bank of needs. By offering a Moratorium as suggested earlier, to the pool of IMDs of 2003-2013, and exploring the skills and experiences of IMDs to match the patients’ needs, we would facilitate a start of a process to capitalize on IMDs’ skills to serve patients. This would be supplementary to the professional care provided by physicians and could lead to a new cost-effective measure for the government and the profession. Moreover, this new program could help IMDs actualize their goal of working in the medical field in Canada, improve their confidence and motivational drive and help them maintain their professional affiliation with medicine. It could alleviate the stress, frustrations, and feelings of disempowerment as an immigrant and as a doctor. IMDs would earn higher wages than in their current underemployed and laborer jobs. They would pay more taxes, which, in turn would benefit the city and go to building schools, hospitals, roads, affordable housing, transit, farmers – to help them produce healthier home-grown foods that would reduce illness and healthcare costs to the government. There are reports, statistics, and stories that show how the health of IMDs and other immigrants deteriorates after arrival in Canada (Press, 2011). A program like this could stimulate IMDs and the economy and make Canada a healthier place. However, further research is necessary to validate these suggestions.

Overall, these actions for change and a moratorium are designed to deal with the backlog of IMDs caught between 2003 and 2013 that put CIMGs in the same competition with IMDs for retraining programs. The IMD Office would advocate for current and future IMDs coming to Canada. It would enable transitioning to medical jobs in the workforce. It would support the policy recommendations I make in Chapter 10.

**Innovate NOT Integrate**

In Canada’s democratic society, every person has the right of choice, freedom, and conscience. No one should have to change their ability, identity, or style of life because of their race, nationality, or sexuality. However, for IMDs, this is different. Although it is not advertised,
it is silently implied that IMDs must change their style to fit in the culture of the profession if they are interested in working as doctors in Canada. The medical education curriculum programs project a code of ethics, as well as professionalism for medical education for residents in training. During the years I worked in the Office of Postgraduate Medical Education at the U of T, I observed IMDs who made enormous attempts to change their outlook as a foreign doctor as they tried to adapt to fit in with the norm of the profession through change of dress style and habits. Despite these efforts, IMDs continue to be labelled with the stigma of immigrants, foreigners and different. Even after they are accepted for retraining programs they end up trailing behind their CMG and CIMG colleagues by at least three months as they complete the required 12-week pre-internship program (Pre-residency Program, 2017).

For example, the academic year for residency education starts on July 1 of each year. Because IMDs must complete a 12-week pre-internship assessment evaluation as prerequisite for their residency training (Pre-residency Program, 2017), if they complete their assessment prior to July 1, they remain in the cohort of residents starting on July 1st of that year. If they start the pre-internship on July 1st, they fall behind the residency cohort by three months. Throughout their training program they carry the stigma of “IMG” or foreign born doctor because of their place in retraining programs, their image, looks and color, as Dr. Amit describes about her experience as a brown doctor in a hospital setting (Belluz, 2012). For some IMDs, throughout their training they trail completion of training program by three months. When their colleagues can join the workforce as qualified doctors immediately after graduation, IMDs fall behind because of the 3-month pre-internship and a further completion of a five-year return-of-service contract in an underserviced community. By the time IMDs are ready to practice independently, they would have completed approximately 13 years postsecondary education outside of Canada, as prerequisite equivalency for an IMD, plus another 2 years family medicine or 5 years specialty training in Canada, 3 extra months pre-internship assessment and the required 5 years return-of-service contract. Altogether, this amounts to a total of 20 ¼ years of education and service for family medicine IMDs or 23 ¼ years for all other specialties.

An “Innovate NOT Integrate” imagination for IMDs (see Figure 22), executed under the recommended IMD Office and DIM Program, is aimed to be able to reimagine new possibilities to capitalize IMDs life-long learning skills and investments for work in areas of the medical field more closely suited to the skills and cultural backgrounds if this is of interest to them. These
jobs would likely be unlicensed specialist jobs, but higher than the underemployed jobs IMDs currently face. The “Innovate NOT Integrate” imagination (Figure 22) is designed to enable more IMDs to maintain their professional identity and career. It would remove victimization of IMDs of feelings of inferiority and underemployed workers, while exploring new ways to re-imagine their skills (as discussed in Figure 21), to better care for the patient population in various communities in Ontario and beyond to other provinces in Canada.

![Diagram](image)

**Figure 22.** Innovate NOT Integrate.

The “Innovate NOT Integrate” model (Figure 22), would move IMDs quicker into employment of medical related jobs, starting in GTA in Ontario and possibly moving out to the greater Ontario and across Canadian provinces as IMDs have indicated on different occasions that they would work in other areas of the country. Re-imagining new possibilities to capitalize on IMDs skills and opening opportunities to work across the GTA and Ontario provides a greater opportunity to see newcomer IMDs moving out of the GTA, and into wider fields in Canada and populate other parts of Canada. It provides an alternative plan to capitalize on IMDs skills to meet patients’ needs and not refer to IMDs as aliens and foreigners unfit to serve in the medical profession.
At national and international exams, IMDs are identified as “aliens” in the registration roster and seating plan. When I drew up the seating plan for North American exams for residents while I worked in postgraduate residency education at the U of T, I was always baffled why immigrant and visa doctors were placed in the “alien” category. I can understand why the visa students were placed in this category, but why IMDs who are immigrants and soon to be Canadians? Was this for lack of better terms? Was it to inflict further racialization and segregation of IMDs as the “other,” “outsiders,” or “foreigners” in the profession? Was it simply a way of identifying international graduates for some other reason? The question is, how can IMDs integrate if these labels follow them wherever they go and are so obvious? Moreover, why encourage IMDs to integrate into Canadian standards when there is no intention to hire them in the profession? Canada claims to be a welcoming, multicultural and democratic country, opened to diversity and equality for all its people but continues to bar thousands of IMDs as foreigners and aliens. How necessary and effective is it to have all IMDs redo the entire residency training of 2-5 years when they are already trained and educated doctors from accredited medical schools recognized by the WHO?

I ask these questions because Canada continues to rely on immigrants. It targets to accept 250,000 newcomers every year, in addition to 25,000 refugees recently and many thousands precarious workers and international students from developing countries who all need a doctor whom they can communicate with and who can understand their problems if culturally associated. A greater majority of newcomers settle in Toronto and other cities in Ontario. Some may be comfortable and prefer a Canadian doctor, others for various reasons, age, lack of English fluency or culture such as my parents and many other people in the various ethnic communities, might not feel so comfortable with a Canadian doctor. This is very crucial with age difference as well. Imagine the awkwardness of a 65 years old female educated immigrant patient with some English language fluency and a 35 or 40-year-old newly minted Canadian female or male doctor in an annual physical check situation.

Also, there may be newcomers or refugees who might not have seen or treated in a Western style medical clinic or hospital. This could be another area where IMDs could provide orientation and education to help these newcomers adjust and understand the Canadian system. More importantly, IMDs could teach newcomers how to use the medical services effectively; how to avoid unnecessary follow-up hospital or doctors’ visits to reduce the healthcare costs.
There are many hospitals and clinic with special programs in different languages designed to help to meet the needs of ethnic and non-English speaking patients, but these programs do not fill the space of a doctor or physician assistant who can tend to the patient’s need and care in a doctor to patient manner. Moreover, using brochures to communicate to patients is assuming that all patients are literate or have the ability to read and comprehend medical words and directions.

Attempts or expectations to integrate IMDs in Canadian medicine for almost 50 years has not worked and might probably never work if the medical system’s structure and practices remain as they are. As more IMDs arrive in Canada, the number of qualified, yet denied IMDs would increase and more IMDs would fall in the same misfortune of the 15 participants in this study. The proposed IMD Office would develop rules, regulations and policies to foster quicker assessment of IMDs for transitioning into residency or other medical jobs in Ontario. Rather, when Dr. Haq and I asked over 50 IMDs who attended the “Confidence Building and You” forum in September 2015 (Appendix L) the questions below, the answers were overwhelmingly positive for all questions:

1. Who would like to work in a limited-licensed Physician Assistant capacity if not offered a residency position?

   *Overwhelmingly yes.*

2. Who would be willing to work in the medical field in a limited-licensed Physician Assistant capacity but in a smaller community outside of the GTA?

   *Overwhelmingly yes, except for a few IMDs who had young families.*

3. Who would move to a small town in rural Ontario if offered a residency position?

   *Overwhelmingly yes.*

4. Who would like to pursue specialty residency in Family Medicine and other fields?

   *Overwhelming yes with several comments about how to maintain recency of training; get financial and professional support; get accurate up-to-date information about the process*

Several attendees approached us at the end of the session. Among other positive comments about the forum, they thanked us for the opportunity to attend a no-free professional development workshop with free refreshments. Many reaffirmed in person they are willing to work in any area of medicine to retain their connection with the profession, including doing
research, working in insurance companies or in labs, or going back to school for a master’s or PhD degrees. Some indicated that they do not have any other skills outside medicine. They would be willing to work as counsellors, doctors’ assistants, or any jobs dealing with patients’ health and well-being, in doctors’ offices, clinics, hospitals, schools or government.

The IMD problem was created from empirical studies and from perceptions that foreign-born and educated doctors are not equally trained as doctors born and educated in English-speaking countries such as Canada. As discussed earlier, Canada has changed from a homogenous, White, English-speaking country to a diverse multicultural mosaic. All peoples in Canada are patients of a single standardized medical structure designed to maintain professionalization and monopoly in the profession (Naylor, 1986). As Banks (1998) points out, if people can view their culture from the point of view of another culture, they can understand their own culture more fully. They are able to see how unique and distinct their culture is from others.

Embracing IMDs with their cultural differences and giving them the opportunity to work and share their culture in the wider community of medicine in Ontario would help doctors and other healthcare professionals in the system. Creating an innovative model as in Figure 22 to capitalize on IMDs’ skills and putting innovation as central to the goal is not only helpful to IMDs and patients. This program, although require further research, does have far reaching impacts in meeting the need for doctors in ethnic communities across the GTA and other parts of the Province. Such a model could see IMDs moving out of the downtown core of the city to the outskirts of the GTA and into the greater corners of the Province, as some participants and other IMDs suggested. Such an innovation could influence future IMDs to explore medical practice outside of Toronto and in the vastness of Canada rather limiting their options to big cities which they are familiar with. Several participants in the study indicated that they were only familiar with Toronto, Montreal, and Vancouver when they applied for immigration to Canada. Using an innovative model as reflected in Figure 22 has the potential to extend diversity of doctors in the GTA, Ontario and across communities in Canada to extend population and build the land. I strongly believe we need to move away from integrating IMDs and explore innovation of IMDs in the broadest sense, for the benefits of patients, IMDs, the profession and Canada.
Why A Diversity in Medicine Program?

Historically, heavy emphasis has been placed on equal access of women in medical schools as representation of equality and diversity. More recently, medical schools have started to focus on increasing student diversity by encouraging a mix of Black, Indian, Chinese, Aboriginal and other students from different ethnic backgrounds. According to Walji (2015), diversity encompasses variations in race, ethnicity, social and economic status, sexual orientation, and physical ability. While optic mix of ethnicity in medical schools is increasing, it is not increasing in residency education with representation of IMDs. Training a diverse group of doctors in medical schools has the potential to enrich diversity in healthcare delivery. However, these new graduates might not necessarily possess the same diverse competence in social, cultural and other healthcare understanding of how health and illnesses of patients from different ethnic backgrounds as IMDs might know.

As mentioned earlier, disparities of accessible care to ethnic minority groups of patients is well documented in the literature. As this diverse group of patients continue to grow with Canada’s needs for immigration and its open immigration policies to accept refugees and other migrants from developing countries, the disparity gap could widen. Further repercussions on accessible healthcare delivery and outcomes to all patients, including newcomers could widen. This could lead to additional burdens to the patients and the taxpayers while several thousands of IMDs are at the cusp of losing their life’s worth of human capital, professional career, identity and dignity among families and communities.

During my work in the postgraduate medical education office in the 1990s at the U of T, patient diversity was portrayed as the 4-Ds—dress, dialect, dance, and diet. Faculty and residents focused on these 4-Ds at academic teaching seminars, workshops, professional development and annual meetings, as new knowledge to deal with patient diversity in patient care delivery. They learned diversity, cultural competencies and ethnic patients need from competent faculty development leaders, who themselves, however, were not from diverse cultural backgrounds, but who sought to learn these competencies through knowledge competencies. While this is to be commended, as Asante (2012), Gunaratnam (2008) and Yosso (2006) claim, cultural skills and understandings cannot be learned easily or from textbooks alone. Asante further argues that it may be a “parade” or hypocritical to pretend to understand another’s person culture and beliefs,
such as the African culture, due to the deep roots imbedded in people and their culture (Asante, 1980, p. 52). Bigby (2003) added that physicians should not only be aware of different beliefs or concepts of health and illness. They need to become skilled in exploring how, or whether these beliefs are important or relevant to a specific individual. Hence, IMDs might be a better source to treat patients of different ethnic and cultural backgrounds and in delivering good doctor-patient communication and relationship.

The Premier of Ontario, Kathleen Wynn, made a very interesting plea to business and corporate leaders at the Canadian Club Breakfast Gala on December 13, 2016. Speaking on the topic of “Unveiling a Balanced Plan to Build Ontario Up for Everyone” (Wynn, 2016), she suggested the following to every business leader in attendance and who have strong financial grounding and over 50 employees:

If everyone hires one disabled worker in this province, the problem of disproportionately high unemployment in disability workers in this Province would disappear […] that would make a huge difference […] lets work together and ensure that every region in this province in unlocking its potential (6:30-6:45)

Considering the great need for doctors in Ontario, the increasing healthcare costs, and the sufferings of vulnerable patients, if each group practice or medical clinic in the communities and hospitals can work together and take one IMD each in their office to support patient-care, could we place 25 IMDs in medical jobs with an above minimum wage salary (see Recommendation #3)? What is preventing this kind of creativity in the medical profession?

Many IMDs have suffered great financial, emotional, health, family and severe professional losses since arriving in Canada. They have lost their dignity and pride. While the need for doctors and other health care services for patients still exist, the DIM program is designed with the expectation to work to help restore some of the dignity IMDs lost from being placed in the same competition with CIMGs since 2003. With no clear guidelines about the transitioning process, limited accessibility to personnel who can help, IMDs relied on colleagues for updated information. This led to much speculations, guessing games and assumptions on the part of IMDs. It creates more frustration and disruptions in IMDs’ lives. Dr. Artmad explained:

We are strangers in this land. How do they expect us to imagine the system? Where do they expect us to get the experience and understanding of the system and the exam? If I want to apply for a driving license, there are training classes I can take before taking
driving exams. This is not the case with the Canadian medical exams. You are on your own.

He continued:

I told my wife and kids, ‘I grew up to be a big surgeon back home. I was like the big tree with all its branches, but circumstances changed and chopped me down…. Now I am like the fertilizer or manure—at the bottom.’

‘I want to be like a tree again, but I have to wait for the good weather to grow again with sprouts and branches.’

Several of the participants described that they felt cheated by the government and the medical profession. If they were not doctors and if their friends and families did not know them as doctors, integrating into society would not have been as difficult. Dr. TFox said:

Going to the church and your friend’s kid who was born in Canada and went back home with his parents remembers you in your White coat and probably became inspired to be a doctor…comes up to you and address you as Dr. So and So, what do you say? Or, when your neighbor next door, or patient from back home is visiting and meets you at the church or grocery store, address you as Dr. and ask where are you working? Not everyone follows the IMD situation in Canada so they do not know the situation. It makes them feel awkward as well, but leaves you feeling that you are a failure.

The DIM program would create opportunities to re-examine IMDs skills and potentials and help those who wish, and are qualified, for employment in the non-licensing fields of medicine and restore value and sense of self worth to their lives.

My Support for a Diversity Program

Walji (2015) posits that a diversity program would aim for inclusiveness of variations of race, ethnicity, social and economic status, sexual orientation, as well as physical ability. The U of T claims it is committed to diversity. It exercises this claim by committing to ensure equality and fairness of all nationality through its advertising and hiring processes (U of T Human Resources n.d.) but as Gaertner, S.L. Dovidio, J.F., Nier, J., Hodson, G. and Hulette, M. (2005) explain, even the most well-intentioned people tend to be racist “unintentionally,” or without being aware of being racist (p. 377). Dobbin & Kalev (2013), also found that diversity initiatives usually start with the government bureaucrats, judges, lawyers and other leadership in an organization but the people who enforce diversity, fairness or equal opportunity in an organization are the managers who are not usually involved in the program. To ensure success
of the DIM Program, it will be important to ensure that all levels of leaders and management are working together in a linear fashion and not a dominant hierarchal dominant fashion. It would be very important to ensure voices of IMDs and other visible minority leaders are involved in the design and establishment of the IMD Office and the DIM Program to be inclusive and have equal representation for a balance leadership team.

As part of my job at the Postgraduate Medical Education office at the U of T, I also organized the schedule for residents’ training with hospital administrations in Toronto and in doctors offices, clinics and hospitals across Ontario. My responsibilities included visiting hospital settings, residents’ stations, doctors’ clinics, meeting with physicians and staff, as well as preparing job descriptions for appointment of new teaching doctors and organizing accreditation reviews. I travelled with accreditation teams to urban and rural hospitals in Ontario as organizer and resource person to the accreditation team and process. I participated in the assessment of programs and residents’ training and curriculum. I shadowed physicians in hospital clinics and operating rooms to gain understanding of a-day-in-the-life of a supervising doctor and a resident in training, organized OSCE exams for all levels of residents, recruited examiners and standardized patients. I organized and monitored the stems for the OSCEs and have 25 years experience in medical education, recruitment, program development and organization of resident training program. I have access to a vast network of medical educators and leaders of the profession. I have the agency and willingness to explore and work towards development for change. With the right team of leaders and community groups, change to resolve the IMD problem as identified in this study is possible.

Definitely there will be pushbacks from stalwart leaders, educators and thinkers. However, if we adapt Lewin’s (1946) common sense and practical model that allows to take a step-by-step, iterative approach and include all stakeholders in a plan to recognize the current problem, determine best ways to tap into existing resources, capitalize on IMDs’ expertise and put them all in a plan for change, the diversity program may yield success.

Connecting with the medical stakeholders and other relevant resources and communities could strengthen the vision for a better and more objective plan. My position as a non-physician with medical education, academic administration, management and networking skills may contribute to determining a more objective plan for action. The Canadian government gives
priority to the health and well-being of all lives. Some provinces, such as Manitoba, are already taking successful steps to retrain IMDs. Last year (2015), the University of Manitoba accepted 19 IMDs from the Philippines, South Africa, and other developing countries (Calgary Herald, 2016). After one year of family medicine training, these IMDs were ready to fulfill their return-of-service contract. Ontario can start a new program with the inclusion of non-physician, specialist and other healthcare workers need, to prepare IMDs for work in the medical workplaces and bridge the gap of patient care needs in its growing multicultural communities.

During my analysis of the data, repeated words and phrases from participants include “lack of confidence,” “wish for learning opportunities/professional development,” and “wish for association with academia, research, higher education and the medical workplace.” Most of these were also repeated with a different group of IMDs at the Confidence Building forum (September 2015). I expected a modest RSVPs of 15–20 to the Forum. Instead I received over 60 RSVPs. Many participants had the feeling that the only work they could do is work as a doctor. They were enlightened when ideas for new possibilities for IMDs in the medical profession came up through discussions at the Forum and the diversity of presenters. Common sense and research tell us that newcomer IMDs need to have their skills upgraded and be oriented before they can have a grasp on the standards and culture of Canadian medicine. With less than 10% of IMDs selected for retraining, is a grave waste and shattered dreams. These costly financial and human wastes should be attended to. They should be remedied. As IMDs are learning people, there should be professional programs for them while they are going through the recruitment system. These could be offered through the recommended IMD Office and DIM Program.

**Overall Benefits in Re-imagining IMDs’ Skills**

Adopting a model to re-imagine IMDs’ international skills in the care of patients is expected to benefit the patients and IMDs in the GTA and across Ontario. It is expected to develop opportunities to place IMDs in transitional medical jobs while providing them the opportunity to experience the practice of medicine and contribute to the societies of Canada. Rather, this experience may expand IMDs’ interests to continue to seek medical re-licensure or ignite re-direction to new interests and alternative careers. This process is expected to remove IMDs from underemployment and minimum wage jobs while providing incentives to aspire towards the Canadian life-style they dreamed about before arriving in Canada. The jobs created
by the DIM program may be permanent or non-permanent jobs. They may most likely be stepping-stone jobs for IMDs to explore their interests in medicine and re-energize their confidence and self-worth as professionals. Very importantly as well, if more IMDs are available in doctors’ offices as physicians or physician assistants to provide triaging and other support care to ethnic patients, these patients will save time and transportation costs to see a doctor of their cultural backgrounds.

Evidently, when Busing (2009) made the plea for 50 more IMGs per year to fill the doctor-shortage and focused on securing the 50 spaces for CIMGs and not IMDs, he referred to the initiative as a “win-win opportunity on a small level” (para. 11). The overall benefit of re-imagining IMDs’ skills in Ontario would initiate a “win-win” for IMDs and ethnic patients on a larger scale. It could likely save the Ontario government costs for interpreters for non-English speaking patients and excess costs for non-emergency hospital visits by patients who do not have access to family doctors. Additionally, the DIM program is targeted to place IMDs in jobs in the medical workforce in the GTA and across Ontario with the intention to reduce dependency on interpreters and create easier access for ethnic patients to reach their doctors without undue travelling costs and time. It would support patients with improved opportunities for better doctor-patient communication in diverse communities. It will put a dent in the doctor-shortage problem that leaves millions of patients with no access to family doctors and other health services, reduce the unequal and unjust access to healthcare for more patients and put IMDs to work for greater contributions to the service of patients, the economy and their personal and professional lives and well-being.

**Conclusion**

Canadian society outwardly commends its ideals of inclusion, fairness, and multiculturalism. However, the dominant power, structures, goals and institutions’ activities do not seem to follow same. These structures continue to exclude foreign born and educated doctors as unsuitable for retraining and practice of medicine. The profession justifies the rigorous barriers of exclusion to certification requirements for IMDs to practice medicine in Canada (Foster, 2008) while the overwhelming majority of IMDs come to Canada with the aspiration “to work in the occupation for which they were trained in their home countries” (Basok, 1997, p. 101). Forcing alternative careers or underemployment of IMDs, especially IMDs who are older
in age, have proven to be very disappointing, frustrating and demoralizing for IMDs (see Chapter 8). It reflects the imposition of discrimination against IMDs as a result of their foreign nature, skills, credentials and language. Although many IMDs resort to alternative careers underemployment, many others find it very difficult to give up their dreams of being a doctor in Canada. They become more determined to pursue medical recertification to obtain their goal to practice medicine. They become more longed for the chance to get back to their career and enjoy the professional acclamations of medicine. They become more in-tuned with possibilities for a better professional and financially stabled life for themselves and their families. However, after many years of denial of access to the profession, rejection takes its toll. IMDs find themselves in a downward dive of social and economic levels in life, but with determination and resilience, they focus on hope for a chance of being selected. They continue to take chances in hope that they will eventually be successful in reaching their goal. They do so for their personal professional desire, their families, and for their children’s future. Re-imaging new possibilities of how to better capitalize on IMDs’ skills as assets to meet a growing need of other non-specialized skills to care for patients, the recommended DIM program and other recommendations listed in Chapter 10, target areas for possible change to capitalize on IMDs skills. They focus on how these skills can meet patients’ needs while creating jobs for IMDs. The final chapter which follows, focuses primarily on recommendations for change, followed by a conclusion of the study.
Chapter 10
Recommendations and Conclusion

This chapter presents recommendations as the form of immediate and long-term goals and policy changes (Weiss, 1995), suggested for resolving the long-standing problem IMDs face as foreign immigrant doctors in Ontario. The recommendations are also designed to aid in eliminating future occurrences of the same problem and streamlining a link to Canadian immigration policies and the Canadian medical profession. Some of the policy recommendations come directly from the participants, in response to the last research question on suggestions for improving the recertification system for IMDs in Canada. Other recommendations come from the literature, analysis of the data, and deduction of practical and common sense possibilities to untangle and capitalize on IMDs’ skills and human capital to benefit IMDs and patients in Ontario communities. With further research and the cooperation of the stakeholders of the profession, educators, leaders, physicians, community and medical associates, and other healthcare inter-professionals, implementation of these recommendations should lead to improving the lives of IMDs and patients. They should lead to influential suggestions for the government and the medical profession for improved the health and healthcare needs of patients and IMDs lives. These recommendations are guided by the theories and methodologies of Lewin, 1946; Gabel, 1995; McIsaac (in O’Brien, 1998), Weiss (1972, 1998), Anderson (2016) and leading scholars in sociology and social justice education. I begin with a synopsis of the recertification of immigrant professionals, followed by a list of recommendations, including goals and policies changes. I then provide suggestions for future research, future actions and a conclusion of the study.

Recertification of Immigrant Professionals

A frequent question I have been asked during this research is: "Aren’t these practices of exclusion of IMDs from the medical profession common to all professions in Ontario and Canada?" The answer is ‘yes’ and ‘no.’ The processes of professional recertification are both structurally similar but at the same time, widely varied in practice. The way in which structural and institutional policies interface with individual agency is also very different. All professional bodies have different supply and demand needs. They have different regulatory, accreditation and evaluation processes, designed to uphold the standards and goals of the profession and its
organization. Medicine deals with the lives of people, ethical standards, effective communication, professionalism and cultural competence. It carries a different licensure process and objectives for the profession from other professions. Medicine also has a longer history of professionalization. It has a longer elitist status and social class in society. The body of stakeholders of the profession is extensive and represents interests of governments, medical schools, licensing and regulatory bodies, medical associations, ethics and evaluation groups and others at a longer arms-length, all of which are crucial to the survival of the profession. Rather, it is the most complex of all professions in Ontario. This makes it more difficult to come up with solutions to recruit highly educated professional doctors as needed by the government and retrain and capitalize on the human capital and credentials of these doctors to add value to the individuals and the various stakeholders. In the end, the IMDs remained tangled in a downward spiral of professional and social mobility, with very little chances to become relicensed (Guo, 2009).

As evident, the number of IMDs accepted in the profession has been in the decline (CAPER, 2011). Why is this happening when the patient population is growing in diversity, the cry for life and death patient care needs in a growing multicultural and diverse province is getting louder? Who do we approach to explore this problem to seek change, more representation of IMDs in patient care delivery and Canadian medical workforce as a means to stop the waste of valuable skills and knowledge IMDs bring to Canada? It is expensive to train doctors in Canada but given the way the profession has been implemented and structured in view of foreign trained doctors, there is no simple answer. According to Olson, capitalizing on the resources of IMDs make sense and should be explored through a Royal Commission involving stakeholders, IMDs, and all levels of government (December 22, 2016). What follows is a list of suggested recommendations for change on this subject, starting with the immediate goals, followed by the long-term goals and policy recommendations.

**Immediate Goals**

**Recommendation 1:**

**Establish a new IMD Office in Toronto**

The government of Ontario should establish a new (Game Changer) one-stop office in Toronto for IMD professionals only. This office should be led by a Chief Executive Director, in collaboration with stakeholders of the professional body, to explore, facilitate and capitalize on
IMDs’ international skills, to complement delivery of healthcare to all peoples of Ontario while transitioning IMDs to the Ontario workforce.

The medical profession encounters the biggest backlog of IMDs seeking medical recertification. The cost for healthcare for the people is increasing while Canada continues to fall to the lower bottom of physician to patients’ ratio in all OECD countries with Canada holding a 2.5 doctors to every 1,000-population compared to 3.2 doctors to 1,000 patients in OECD countries (OECD, 2014, p. 2). This new IMD Office will serve as the primary IMD site with trained personnel who understand IMDs and the medical profession, and in turn can provide effective assistance to guide IMDs in their search for medical recertification. A similar suggestion for a game-changer office was made by Ontario Court Judge Marvin Zuker (2016) during his sentencing in a sexual assault case.

Justice Zuker suggested that the Ontario courts design a special office to train officers, crown attorneys, and personnel to understand the complexity and myths surrounding rape cases and victims of sexual assault. I see such a “game-changer” office with qualified personnel, as an effective way to handle the thousands of IMDs who are caught in the web of government promises, licensing and regulation barriers, professional structure and protectionism to maintain status-quo - who can in turn be working and contributing to patient care and the Ontario economy.

Recommendation 2: Establish a new IMD Diversity in Medicine (DIM) Program

Establish a new Diversity in Medicine (DIM) Program to better assess IMDs for work and delivery of patient care in the Ontario communities. Housed in the new IMD Game-changer Office and managed by an Executive Director, the DIM program would assess and match IMDs to physician and non-physician specialist positions in doctors’ offices in clinics, hospitals, and community centres and for negotiating funding and salary recoveries from various sources to support this endeavor. It would also be responsible for redirecting IMDs to other professional career pathways if retraining residency positions or other medical-related careers are not viable options.

The DIM Program (Figure 20) presents a Blueprint for strategizing and gathering skills and talents of IMDs, as well as needs from doctors’ offices (in private settings, hospitals, clinics
and centres), schools and other profit and non-profit organizations and centres. It would seek out
the need for IMDs skills in the various settings and match IMDs to physician/offices. The DIM
Program would provide an avenue to tap into IMDs’ unique blend of foreign and Canadian
informal medical education, knowledge and skills. It would provide an avenue to extend IMDs’
untapped blended resources in caring for the vastly diverse communities of patients in Ontario
for a salary to be recovered from the Ontario government and doctors/hospital administration.

**Recommendation 3:**

**Offer a Moratorium to IMDs who consistently applied for medical recertification**

**between 2003–2013**

*The Ontario government should offer a two-year Moratorium to IMDs who have met the CaRMS
requirements for application for a retraining residency, but denied and continued to seek out
opportunities between 2003 to 2013. IMDs were placed in the same competition with CIMGs in
2003 for the same retraining positions for IMGs. This Moratorium would provide an opportunity
for IMDs caught in the IMG competition with CIMGs and until the time of data collection for
this study in 2013. I recommend that:*

1. The government of Ontario supports 50 non-specialist physician assistant positions for
   IMDs over a two-year period (25 positions in year 1 and 25 in year 2), to address the
   backlog of IMDs between 2003-2013 with:
   a. 10 positions to be in hospital settings
   b. 15 positions to be in community practices, centres, clinics, private offices,
      schools, etc.
2. The government of Ontario commits to 50/50 split salary of $50,000-$60,000 per year for
each of the 50 positions.
3. That hiring physician/clinic/hospital provide the 50% of the salary for the IMD.

This Moratorium is a way of introducing innovation in the Ontario healthcare system while
providing IMDs with jobs and capitalizing on their skills for patient care. It does not increase
residency positions for IMDs or supplement/replace the CaRMS application process. IMDs who
prefer to continue with the CaRMS match process are welcome to do so.

Currently, IMDs are required to retrain and have a valid license before they can work as
medical doctors in Canada. As discussed, only a small number of IMDs are selected for
retraining and re-licensure. The remaining thousands of IMDs qualified for retraining continue to
reapply in the hope that their chances for selection are successful. Unfortunately, this continuing
hope has made it harder for IMDs because securing a residency position fails and switching careers becomes more difficult and has severely impacted the professional lives of these IMDs.

The moratorium would allow for reassessing IMDs’ skills for practical use in Ontario communities. It would open new channels for addressing the needs of patients who do not speak English and do not currently have access to doctors of similar backgrounds. It would give IMDs a last chance for a job in the medical area. It would put an end to the hope and expectation for medical re-licensure and expose IMDs to other kinds of jobs in the medical field.

Determining the availability of jobs and developing job descriptions for IMDs would require a database of the skills needed in different physicians’ offices and the skills offered by IMDs. The database would be compiled through surveys, applications, and interviews. IMDs would be placed in jobs in consultation with university medical schools, the CPSO, RCPSC, CFPC, and experts in Human Resources. Assessing IMDs independently of the CaRMS process would be required to determine the need for non-residency training in areas identified by community physicians. I would design a program to collect and compare the skills between community needs and IMDs who have met the CaRMS requirements up to 2013, the year I started the data collection for this study.

**Recommendation 4:**

**Increase the Ethnic Physician-to-Population Ratio**

*The Ontario government should create a separate quota for IMDs (outside of the CIMGs) in Ontario medical schools. It should increase the intake of IMDs by 50% to start bridging the imbalance of ethnic doctors to ethnic patients. This should start immediately and continue for five years or until the gap is narrowed. It will reduce the doctor-shortage and high cost of emergency hospital visits by patients who lack access to family doctors.*

There is a steep imbalance of ethnic doctors in the medical profession. Although Ontario medical schools are trying to diversify their intake of medical students to reflect the growing diversity of patients in the province, it is unlikely that these students will have the same cultural and linguistic wealth as IMDs. In 2007, the intake quota for IMDs was 200 (Thomson & Cohl, 2012). By 2014, 112 CIMGs were accepted for retraining positions versus 109 IMDS and 1,013 IMDs denied access to retraining residency positions in Ontario in 2014, compared to 269
CIMGs. Yet almost half of Ontario’s population consists of diverse ethnicities, with people speaking over 140 dialects. There exists a significant imbalance in the ratio of ethnic doctors to ethnic patients. This recommendation would also reduce the long wait for treatment of life-threatening illnesses that has been on the rise (Barua & Esmail, 2013). In addition, while immigration increases, baby-boomer physicians continue to retire or reduce their patient load. The shortage of doctors will continue as the newcomers seek medical care. Increasing the IMD retraining quota will stabilize the needs.

**Recommendation 5:**

**Increase IMD Positions to Fill the Doctor Shortage**

*The government of Ontario should increase the number of IMD retraining residency spots in the province (number to be determined after analysis of needs is conducted) to reduce the doctor-shortage and high cost of emergency hospital visits by patients who lack access to family doctors.*

This recommendation would also reduce the long wait for treatment of life-threatening illnesses that have been on the rise (Barua & Esmail, 2013). In addition, while immigration increases, baby-boomer physicians continue to retire or reduce their patient load. The shortage of doctors will continue as the newcomers seek medical care. With the steep imbalance of ethnic immigrant doctors with international expertise in the doctor population, the government should provide increased residency retraining positions to increase the number of IMDs in the profession to meet the current and future needs for adequate representation of ethnic doctors in the system.

**Long-Term Goals**

**Recommendation 6:**

**Research, Teaching, and Professional Transitioning**

a. *In addition to residency retraining, IMDs should be encouraged to pursue other areas of medicine such as basic and scientific research.*

The growing changes in the demographics of Canada's population bring new ailments, diseases, and cultural and linguistic needs. Understanding how immigrants from different backgrounds adjust to Western medicine can support new areas of research. This research, and
dealing with new and evolving medical issues in a diverse patient population, should be given serious consideration by stakeholders of the profession.

b. The Ontario government should capitalize on IMDs’ international expertise to help build Canada’s already high reputation for medicine by:

1. Increasing the number of IMDs in retraining residency programs for medical recertification (see Recommendation 5)
2. Linking with OISE to offer scholarships for comparative national and international medical research
3. Identifying professional and continuing education courses and programs to provide IMDs in the DIM program and those seeking residency retraining with opportunities for growth in both clinical and non-clinical medical jobs
4. Providing guidance to IMDs on new careers in 21st century workplaces, rather than limiting them to underemployment
5. Establishing an annual scholarship for one master’s degree for research, professional, or business interests for IMDs as an incentive to career transitioning and giving back to the profession and society
6. Preparing IMDs in residency programs and other medical fields to develop their leadership skills and become involved in the governing bodies of the medical profession to increase visible minority representation in decision making.

Policy Recommendations

The final research question in this study focused on recommendations by IMDs for improving the medical recertification system in Canada. In general, the findings show that IMDs want straightforward directions and guidelines, and honest information about job vacancies, qualifications, and assessment and selection criteria at the time of applying to immigrate. They prefer a specific time limit and restrictions on testing their ability to practice medicine in Canada. This would enable them to seek other career paths before spending all their savings on the relicensure process. The following two recommendations (7 and 8) suggest policy changes to avoid the suffering and waste of IMDs’ skills, talents, and financial resources.

Recommendation 7:

Policy Changes for the Government and the Medical Profession

1. The government should clearly align immigration policies in recruiting foreign doctors to more specifically identify job vacancies, work in unison with the profession to confirm vacancies, and offer visas according to vacancy needs
2. The government should only accept IMDs if there are jobs available and if it can link applicants to jobs. Pre-assess and pre-approve IMDs for retraining and jobs before they arrive in Canada. If not, push IMDs to write the exams as soon as possible after they arrive in Canada, with a maximum of three chances at the exams within five years of their date of arrival.

3. Professional bodies should set definite cut-off exam marks. IMDs who fall below the cut-off point should be notified and not be encouraged to reapply for retraining positions.

4. IMDs who fail to meet the cut-off point in the exams should be given assistance for second career options rather than left to figure out what to do next or live in hope for several more years.

5. Open new research programs for IMDs to pursue collaboration with Canadian researchers in cultural and intercultural medicine, education, diseases, and other health issues.

6. Have a one-stop website listing all the guidelines, instructions, dates, pathways to different specialties, and contact persons. It should make clear all the “must” requirements without using the word “may.” May leaves too many doubts in the minds of IMDs, gives the impression that there are loopholes, and raises the expectation that if they work hard, they might be rewarded.

7. Create separate intake quotas and evaluation/assessment processes for IMDs and CIMGs.

**Recommendation 8:**

**Prevent Future Backlogs of IMDs**

*The proposed moratorium may remove the backlog of IMDs who, since early 2000, are included in the same quota pool with CIMGs. A procedure such as this may likely avoid future backlogs of new IMDs in Ontario. Moreover, the following recommendations are meant to ensure a speedier process for IMDs seeking medical recertification in Ontario:*

1. Create a separate pathway outside of CaRMS to assess IMDs for retraining.

2. Establish clear and transparent guidelines, policies, and procedures for new IMDs to help them better plan for career assessment and transitioning. This would assist in preventing IMDs from making assumptions about their eligibility for retraining programs. It would also assist in removing any disguises, ambivalences, and labelling of IMDs as immigrant, inferior, second-rate, or foreign in comparison with CMGs and CIMGs in the crucial interview process.

3. Provide IMDs with a one-to-two month observership/mentoring opportunity within three years of their arrival in Canada. During the five-year period, IMDs should able to complete all the required Canadian exams and gain understanding of the Canadian medical system through observerships and other connections with physicians and inter-professional healthcare personnel in various settings of the profession.
4. Provide IMDs with more accurate costs, timelines, and chances for medical recertification prior to arriving in Canada.

5. Link IMDs to the new game-changer office as their first point of contact on arrival in Ontario.

6. Limit the number of times IMDs can write the Canadian exams.

7. Synchronize information with major programs such as CaRMS and HealthForce Ontario to support “one-stop” information service for newcomer IMDs.

8. Give IMDs feedback about their strengths and weaknesses in CaRMS and the interviews to assist them with future planning and career transitioning.

**Recommendation 9:**

**Develop a Modified CanMEDS Contract for IMDs**

*Develop a modified CanMEDS two-way contract as an evaluation tool for IMDs during residency retraining programs.*

The current CanMEDS Framework is a one-way, top-down evaluation of Canadian graduates who have Canadian experience in medicine and are familiar with the healthcare system. It is not ideal for assessing foreign trained and educated IMDs in residency retraining. From what I have observed in my work in medical offices, residents in training sometimes never see their supervisor because of the busyness of the program. Often the supervisor and the residents (including IMDs) miss face-to-face meetings at the beginning of the rotation, mid-way through or at the end. This is problematic for IMDs who are new to the program and the players in the training programs. Moreover, the rotation evaluations provide the sign-off for resident’s completion of the training program and eligibility to write the final certification exam. As Thomson and Cohl (2011) and Schabort, et al (2014) note, majority of IMDs fail the final recertification exam.

Introduce a CanMEDS contract that includes a mandatory face-to-face orientation meeting between the supervisor and the IMD to review the goals and objectives of the program and evaluation. Discussions could include how to amend the list of objectives for the training to better prepare the IMDs with missing skills and education, for the rotation, a mid-term meeting, and an exit interview at the end of the training period.
Recommendation 10:

Recruit IMDs to Academic Teaching, Administration & Continuing Education

The medical profession should use the assessment of IMDs to identify other areas of strength that could lead to participation in the profession beyond the delivery of patient care.

Visible minority IMDs with diverse language and cultural skills are significantly under-represented in the academic teaching and administrative sectors of medicine.

1. Recruit and prepare IMDs to take leadership roles in these positions, to support intercultural education and knowledge sharing.
2. Recruit more IMDs to serve as a good role models for visible minority students.
3. Recruit more IMDs to positions in academic teaching, administration, and continuing education.

Recommendation 11:

Re-imagine Opportunities for IMDs in Canadian Workplace

1. Provide opportunities for newcomer IMDs who have met the CaRMS requirements for retraining programs within three years of arriving in Canada, to gain a three-month workplace experience in preparation for residency interviews.
2. Organize a career opportunities “fair” for IMDs.
3. Encourage outside-of-the-box exploration for transitioning careers

Future Research

I have identified several suggestions for future research throughout this study to clarify and add value to the findings and the literature, especially in the areas of change and diversity as related to IMDs and ethnic patient care. It is important to understand the barriers IMDs face in medical recertification. It is important to develop new mechanisms and pedagogies to combat barriers in our democratic and multicultural country. I have make recommendations for a new IMD Office and provide a Blueprint to establish the structure of a new DIM program. However, the costs of developing such a program, setting up an office, and offering a Moratorium to IMDs require further research for feasibility and accurate planning and implementation.

Further research is also needed to collect data to substantiate the feasibility of the above recommendations for effectiveness, transparency, improving patient health, and improving the prospects for IMDs. As I am recommending changes to an existing profession, it is important to
work alongside stakeholders of the profession, healthcare experts, and the government. Many existing resources can be tapped, but it is necessary to bring these resources together to change the existing program for IMDs and develop more innovative and diverse opportunities for paid work for IMDs in the medical and non-medical workplace. Thus, I suggest further research to determine the needs of patients in the GTA and across Ontario’s communities to determine how effectively a DIM Program utilizing IMDs’ skills and talents could meet these needs.

Finally, the health and well-being of individuals are crucial to maintaining a healthy workplace and economy. Conducting a follow-up study with the IMDs in this study to measure the progress and satisfaction in their lives in the next five-years, would be an important future research project. Conducting research measuring to what extent the frustrations, fear, depression, family split-up, loss of income and professional identity and status caused due to denial of medical recertification, contribute to the health, well-being and spirituality of IMDs would be valuable research to pursue.

**Future Action**

This research is timely and at a critical stage of intervention. I suggest the following actions as the next steps for this study:

1. Seek support and funding from the Provincial and Federal governments and other medical and community stakeholders, to establish and sustain a game-changer IMD Office in Toronto for IMD professionals only (Recommendation #1)

2. Include in the funding proposal, a budget to sustain the IMD Office, deliver a DIM program (Recommendation #2) and offer a Moratorium for IMD who have continued to seek medical recertification between 2003 to 2013 with 50% salaries and compensation for 50 IMDs (25 each in two consecutive years) to work in the medical settings doctor’s offices (Recommendation #3)

3. Organize a follow-up “Networking, Career, and Confidence Building” professional development forum and use part of this session to brainstorm interests, skills, resources, and support from IMDs as defined in the Non-Homogeneous Model for Change (Figure 21) for the DIM program and IMD office.

3. Organize a forum of representatives from the medical profession, MOHL-TC, Immigration, CPSO, local and ethnic communities, and IMDS to discuss the projected “Innovate NOT Integrate” plan (Figure 22) for the DIM program for IMDs. The forum should also include leaders of higher education programs to speak to educational opportunities for IMDs, and IMDs’ credentials for eligibility for masters or doctoral studies.
Conclusion

This study examines the life experiences of “immigrant” medical doctors (IMDs) who came to Canada, motivated to continue their professional career, met the requirements for retraining for medical recertification, but then denied an opportunity to proceed. “Qualified, yet Denied.” Applying a qualitative research methodology with grounded theory, I interviewed 15 IMDs of visible minority backgrounds from 14 different countries in Asia, Africa, the Middle East, West Indies, Eastern Europe and South America. All participants held a MD or equivalent degree from accredited medical schools and all except one, obtained specialization field in medicine. All have met the CaRMS requirements necessary for a retraining residency program leading to a license to practice medicine.

The aim for this study was to determine the impacts caused on IMDs’ professional, personal and social lives from their perspectives, after they are denied retraining programs for medical re-licensure. The analysis of the findings throughout Chapters 6-9 shows the severity of the impacts on the lives of participants who are professional immigrant doctors (IMDs), motivated to find success in Canada, and failed repeatedly. Participants’ age ranges from 35–50+ years (Figure 23). With no retirement age in Canada, IMDs come with the expectation to work and contribute to their old age living in Canada. They expect to work and contribute to the Canadian economy for 15-30+ years.

Most participants are married with children (Figure 24). They come to Canada for a better life in a politically safe and democratic country for themselves and families.

![Age Distribution](image)

**Figure 23.** Participants’ age distribution.

![Marital Status](image)

**Figure 24.** Participants’ marital status.
They expect to become recertified and practice medicine, be role models to their children, care for the Canadian patients and contribute to the country’s economy. IMDs become very optimistic of their chances for recertification after they pass the Canadian exams, and especially because Canada has a dire need for doctors.

Many IMDs who are denied an interview or a retraining position at their first and second attempts, accept the experience as the learning curve. They overlook the negative experiences and as part of the recertification process. Subsequent denials however, set in fear and frustrations. Fear - because their reserve finances to prepare and write the exams to secure recertification is depleting quickly. They must find work to supplement their living expenses but then this limits their study time and makes preparation for future CaRMS applications difficult. Frustrations - because there are vacancies for doctors, they meet the requirements and they are not being considered to fill the need. They are required to compete with CIMGs who are not labelled with the same deficiencies of culture, language, credential and immigrant stigmas as they do. The retraining quota for IMGs is now shared with CIMGs and increasingly more CIMGs are selected over IMDs to fill the retraining positions. There is also little personal guidance available to IMDs to help them better prepare for future CaRMS applications or other transitional jobs. In time, their lives and livelihoods are starting to digress downwards rather than progressing upwards.

The administrative and governance structures of the medical profession aim to maintain, with modifications, a standardized mono-lingual and mono-cultural medical curriculum for all doctors in Canada. This curriculum, rooted from the historical Eurocentric British model, now adheres to the macro restrictive Canadian CanMEDS framework and does not appear as the most adequate framework to assess IMDs in areas such as being a good collaborator, leader, manager or health advocate for patients. As IMDs are new in the country, having these skills and networks are almost impossible. IMDs do not have the same opportunities as CMGs to gain Canadian experience in the medical field to develop such competencies. Nonetheless, they are expected to match up to Canadian residents during the residency competition.

To place IMDs in a competitive pool with CIMGs for the allotted quota of IMGs positions, puts IMDs at a severe disadvantage. The fear, frustrations and delve into underemployment and poverty level salary continue to grow. As more new IMDs arrive in
Canada each year, and fewer numbers accepted for medical recertification, the waste of IMDs’ skills and human capital would grow to significant amount of wastages while millions of people continue the plight of no access to family doctors and other healthcare needs; and while parents and families struggle as they wait for the doctor in their family to regain a license to be a doctor in Canada. If actions are not taken to mitigate this problem, more families will suffer and the healthcare cost will rise. As IMDs fall sick and cannot work, seeking medical help will cost the government money rather than the reverse of IMDs contributing to the economy.

In the past decades and even centuries, conditions have changed demographically, economically, and culturally. Thus, I feel some changes are needed to avoid lives being hurt, fears in immigrants and push to brokenness of spirit and emotions. The recommendations I make here are designed to address the current problem IMDs face in Canada. They are designed to find solutions for today’s IMDs and society, but also for tomorrow’s Canada and its people – immigrants, refugees, children, adults and the aged. We need to coordinate for the better of all these people and the processes that make things work.

I have used theories to be pragmatic and to focus on the actors and parts of the complex medical profession. Nonetheless, we need to find solutions through practical means as Lewin and Weiss show us, and we need to start soon. An email I received from an IMD who attended my Confidence Building and You Professional Development Forum (Appendix L) sums it up for me. This is what she says (September 16, 2016):

I arrived in Canada full of dreams and energy, but somewhere along the way, I felt I lost it all and more.

I am grateful in the middle of all the uncertainty. I volunteered and offered to help paint a positive picture for all who were worried about losing their identity as doctor and resigning from the profession and service. I am particularly concerned how this stress affects our health. You might not believe me, but at least 30% of my IMD families have suffered from cardiac diseases and mental health problems and at least 50% have endured coronary bypass surgeries and lifelong medicines to sustain qualify of life. It is unfair to pretend to offer so much when there is no opportunity to achieve it.

“Daddy, where are you going today? Are you a doctor yet?” asked Dr. Eddie’s little girl as he (a single parent) was leaving her home with the babysitter on an early Spring Saturday morning to go to the Ontario IMG School.
Personally, I recognized the problems IMDs faced in medical recertification. I wondered about the impacts rejection may have on their lives and the families, looking at it from my positionality as an immigrant of color, a parent trying to raise a family and working in the U of T medical school. While I recognized institutional dominance, colonialism, discrimination among other inequities at play to some extent, my personal vision has been one of what can do to make change or correct the problem. Sixteen years of part-time undergraduate to doctoral studies and unwavering support from my supervisor, committee members, colleagues and friends, I have studied the problem in depth and derived a list of recommendations for change discussed earlier in this chapter.

This last comment from my supervisor, Paul Olson and Committee member, Peter Sawchuk, I feel, is a succinct wrap-up of this study from a sociological perspective of the problems IMDs face in Ontario. They said:

Curious as it may seem, this is the origin of the social structural creation of incompetence. Candidates believe in the model of certification because it is a process which, in their own local world, has served them. Yet they, like Genovese argues also, begin to see the oppression of their own exclusion. Economically, in terms of definition of self (by oneself and others), IMDs experience loss, anger, loathing, and for many for the first time in their life, a sense of ‘failure.’ (thesis feedback, December 22, 2016)

In closing, getting it right is too important on too many levels to ignore. I, and I hope others, believe in the goodwill, intelligence, and flexibility of Canadians, immigrant or native born. This is an economic, labor, immigration, and social justice issue. Institutions serve people. If not, why do we have them? IMDs come to Canada with financial resources to afford recertification but the findings in this study show that even if they become qualified for recertification, they are disqualified. The voices of the IMDs in this study give us a window on how and where we should go. I hope others, both inside and outside the medical system, will join in this ongoing journey.
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U of T Postgraduate Medical Education Information, Faculty of Medicine, University of Toronto

U of T (2010) stand on good governance is public accountability, transparency, excellence in teaching and research, stewardship, and diversity of representation of governors.


Appendix A:
University of Toronto Meets Ghanaian Universities Forum

University of TORONTO MEETS GHANAIAN Universities

A JOINT FORUM

PERSPECTIVES ON THE INTERNATIONALIZATION OF HIGHER EDUCATION
FROM NORTHERN AND SOUTHERN ENDS
Afoa Donkor’s Villa, Asokore-Koforidua, Ghana
Saturday, December 5, 2015

Program

10:15 am Registration
10:30 am Welcome – Cindy Sinclair (UT, OISE, SJE)
Greetings from University of Toronto – Dr. George Dei (UT, OISE, SJE)
Greetings from All Nations & University of Education, Dr. Kolawole Raheem, Centre for School & Community Sc & Technology Studies & Institute for Educational Sc & Research & Innovative Studies, Winneba, Ghana

10:45 FORUM: University of Toronto Meets Ghanaian Universities
• Introduction of guests and participants
• Overview of Canada as country, UT, OISE, Toronto – Cindy Sinclair
• Overview of Ghana as a country, Universities in Ghana – Prof Raheem
• Administration: Students, Faculty Liaising – What makes a successful student? Kristine Pearson, former SJE Education Liaison Officer
• CIARS – What is it? Goals and Missions – Anila Zainub, SJE PhD Student, and Ximena Matinez, PhD Student

12:00 DISCUSSION: Possibilities for Future Partnership in Education & Research between CIARS, OISE, UT & Ghanaian/African Universities

12:50 Break
1:00 Presentations, Q&A and Feedback from Professors
• Cindy Sinclair, PhD Candidate, Imagining Possibilities of Medical Education: An International Perspective with Ghanaian Universities, UT
• Cassandra Martin-Weiler, PhD Student, Ghanaian Universities students
• Anila Zainub, PhD Student, Advancing the Goals of Anti-colonial Education through Increased Internationalization with Ghanaian Universities
• Sylvia Kwaemaa Dwamena, PhD Student, Ghanaian Universities
• Francis Xavier Adams, PhD Student, Ghanaian Universities
• Evans Asante, PhD Student, Ghanaian Universities
• Lucy Efneh Attoh, PhD Student, Ghanaian Universities
• Dr. Kolawole Raheem, How to preserve African Culture through Education and Research, Head, Centre for School & Community Sc & Technology Studies
• Ximena Martinez, PhD Student, OISE, UT, The Oasis Without Water: Reflections on the Program of Intercultural Education in Chile and its Vocation for the Reproduction of Indigenous Cultures

2:15 Wrap-up – Thank you!

2:25 Reception – Sponsored by OISE Alumni & Innovations & Alumni Association

Organizers:
Cindy Sinclair, PhD Student, UT, OISE, SJE
George Dei, Professor, UT, OISE, SJE
Isaac Darko, PhD, UT, OISE, SJE Alumni
Kolawole Raheem, Professor, Winneba University

Special thanks to: Sim Kapoor, Associate Director, OISE, Alumni External Affairs for making this sponsorship possible

Peer Reviewed Referees:
Professor George Dei
Dr. Isaac Darko
Cindy Sinclair, PhD Candidate
Appendix B: Interview Protocol

Title of Research: Immigrant Medical Doctors in Canada: Life Experiences After Being Denied Medical Recertification

Date of Interview: _______________ Time: _______________ ID #: __________

Name of participant: _______________ Pseudonym: _______________

Introduction

☐ Thank you for agreeing to participate in this important study on immigrant medical doctors (IMDs)

☐ There are no right or wrong answers to the questions I will ask you

☐ No special knowledge is required to answer the questions

☐ As noted in the Consent Form (Appendix A) which we will review together, the questions will be open-ended in a semi-structured face-to-face 60-90 minutes’ interview

☐ I will provide you with a list of the questions so you can follow along with me

☐ If you do not understand any question, or would like clarification, you will not hesitate to ask me

☐ All your answers and the entire interview will be treated with strictest confidence and anonymity

☐ With your permission, I will audio record the interview

☐ If you consent to the interview, we will both keep a copy of the signed Consent Form

☐ Thank-you token in appreciation of your time
Appendix C:
Consent Form

Date: ________________

Dear Dr. ________________:

Thank you for your interest in my research study. I am a PhD student in the Department of Humanities, Social Sciences and Social Justice Education (HSSSJE) at the Ontario Institute for Studies in Education (OISE), University of Toronto (UT). As part of my PhD thesis, I am exploring what pathway(s) immigrant IMDs’ lives take after they are denied a license to continue their medical career in Canada.

I am pursuing this research because, according to scholarly literature, the majority of IMDs from developing countries other than the US, UK, Australia, New Zealand and Western Europe, are denied opportunities to continue a career in medicine in Canada. To this end, my study seeks to gain a deeper understanding from the voices of IMDs themselves: in particular, how they deal with being denied the opportunity to continue their career in medicine in Canada; and how this denial impacts their lives (negative and/or positive) from a professional and a personal perspective. In addition, this study seeks to explore suggestions that could be used to advocate for improved recognition of IMDs’ human talents in a country as diverse as Canada.

I am applying a qualitative research method to collect data for this study with immigrant IMDs who were born in various international countries and are living in the Greater Toronto Area (GTA). The interviews will be face-to-face (one-on-one) in a semi-structured format for 60-90 minutes each and will be strictly confidential. You are encouraged to ask questions at any time as your suggestions and concerns are important to me. Please feel free to contact me at any time at the information below.

Following some demographic questions, I will ask you to talk a little about themselves and to highlight what inspired you to immigrate to Canada. I will then proceed to ask you some open-ended questions and invite you to address the questions as you see fit. With your permission, I would like to audio-record the interview as a back-up to remind me of our conversation and fill in any missing gaps to ensure accuracy in my transcription and data analysis. The interview is on a voluntary basis and will be strictly confidential and anonymous. Should you feel you have any reasons for withdrawing or leaving the interview, please do not hesitate to do so. No questions will be asked.

Confidentiality

I guarantee that your name and another other personal data and information you provide during the interview will be treated with strictest confidence and anonymity. All names, location, affiliations and anything that would divulge your identity will be withheld from all written and non-written documents, materials, and activities related to this interview. All information you provide, including the audio-recording, will be kept safely under lock and key at all times in my home office. I will not share any information with other parties. I will destroy all data at the completion of this study, or according to departmental and UT Ethics guidelines.
**Risk or Harm associated with the interview**

There is no risk or harm associated with participating in this study or in the interview.

**Benefits of the Study**

This study will provide new insights of the life experiences of highly educated and professionally trained IMDs in the aftermath of denial of medical recertification in Canada. By describing, in their own voices, the impact of not being able to continue their life-long medical career in Canada, will fill the gap in the literature which currently lacks the IMDs' own perspectives in these areas. Moreover, the new data derived from this study could be used to advocate for improved recognition of IMDs’ human talents in a country as diverse as Canada.

**Value Judgment**

No value judgments will be placed on the interviews or the data collected at the individual interviews.

**Ethics Approval**

This study has been approved by the UT Ethics Board. Please feel free to contact the Board at any time for clarification regarding your rights to participate in this study, at telephone 416-946-3273 or email at ethics.review@utoronto.ca.

---

**BY APPENDING YOUR SIGNATURE BELOW, YOU ARE AGREEING TO THE FOLLOWING:**

- ✓ That you have received a copy of this letter and you understand the purpose of the study
- ✓ That you understand the conditions of the study as stated in this letter
- ✓ That you are voluntarily participating in this study
- ✓ That, as a participant in the study, you can decline to answer any questions posed to you at any time during the interview
- ✓ That you can withdraw your consent to participate in this interview at any time, and/or leave the study at any time without have to give reasons for leaving or face any consequences
- ✓ That, I, the Researcher of this study, is available by email at c.sinclair@mail.utoronto.ca or telephone at 416-491-0589 to address any questions you may have about the study
- ✓ That you are entitled to receiving a summary of the findings of this study at the completion of the study should you so wish.

- □ I, ……………………………………………………………………………………………………, wishes to receive a copy of the general summary of this study at email: ____________________________________________

- □ I don not wish to receive a copy of the general summary of this study.
Name of participant (please print): __________________________________________

Signature: ___________________________ Date: ______________________

Name of Researcher (please print): __________________________________________

Signature: ___________________________ Date: ____________

On behalf of my Supervisor, Professor Paul Olson, a faculty in HSSSJE at OISE, UT, we thank you for your participation in this study.

Cindy R. Sinclair, PhD Student
Humanities, Social Sciences &
Social Justice Education
OISE, University of Toronto
Rm 12-254, 252 Bloor St. W.,
Toronto, Ontario M5S IV6
Tel: 416-978-0408
E-mail: c.sinclair@utoronto.ca

Paul Olson, Professor & Supervisor
Humanities, Social Sciences &
Social Justice Education
OISE, University of Toronto
Rm 12-254, 252 Bloor St. W.
Toronto, Ontario M5S IV6
Email: paul.olson@utoronto.ca
Appendix D:
Advertisement

Immigrant Medical Doctors NEEDED
For Research Study

If you answer “yes” to the questions below, you are eligible to participate in a 60-90-minute face-to-face interview with Researcher Cindy Sinclair.

➤ Please contact me soon by email: c.sinclair@mail.utoronto.ca or phone 416-————

Eligibility Questions:

□ Have you completed the Canadian Resident Matching Services (CaRMS) process but have not been selected for medical retraining in Canada?

□ Were you born in a country other than the US, UK, Australia, New Zealand and Western Europe?

□ Did you obtain your MD degree/equivalent outside of the countries listed above?

□ Did you immigrate to Canada in the last 20 years?

□ Do you live in the GTA such as Toronto, Mississauga, Brampton, North York, Scarborough, etc.?

□ Are you between the ages of 28-50+?

This study seeks to gain a deeper understanding from the voices of IMDs themselves: in particular, how they deal with being denied the opportunity to continue their career in medicine in Canada; and how this denial impacts their lives (negative and/or positive) from a professional and a personal perspective. In addition, this study seeks to explore suggestions that could be used to advocate for improved recognition of IMDs’ human talents in a country as diverse as Canada.

➤ Limited number of participants required.

➤ This is our opportunity to make a difference - DON’T MISS IT.

Tear off------ and contact me soon.
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Dear Doctor __________________:

The scholarly literature on the topic of immigrant medical doctors (IMDs) from international countries other than the US, UK, Australia, New Zealand and Western Europe, shows that the majority of these IMDs are denied opportunities to continue their career in medicine in Canada.

I am a PhD student at the Ontario Institute for Studies in Education (OISE), University of Toronto (UT). As part of my PhD thesis I am exploring the issues that shape immigrant IMDs’ lives after they are denied a license to continue their medical career in Canada. To this end, my study seeks to gain a deeper understanding from the voices of IMDs themselves: in particular, how they deal with being denied the opportunity to continue their career in medicine in Canada; and how this denial impacts their lives (negative and/or positive) from a professional and a personal perspective. In addition, this study seeks to explore suggestions that could be used to advocate for improved recognition of IMDs’ human talents in a country as diverse as Canada.

I am seeking to interview 10 IMDs from various international countries other than those mentioned above, who are living in the Greater Toronto Area (GTA). The interviews will be face-to-face (one-on-one) in a semi-structured format. Each interview will be 60-90 minutes in length and will take place at a mutually convenient time and location for the Participant and the Researcher. The interviews will be strictly confidential and anonymous to protect the participants’ identity.

If you answer “yes” to the questions below, I would like to invite you to be a part of this confidential study. Please contact me at 416-491-0589 or c.sinclair@mail.utoronto.ca.

Eligibility Questions:

☐ Have you completed the Canadian Resident Matching Services (CaRMS) process but have not been selected for medical retraining in Canada?

☐ Were you born in a country other than the US, UK, Australia, New Zealand and Western Europe?

☐ Did you obtain your MD degree/equivalent in a country outside of the above listed countries?

☐ Did you immigrate to Canada in the last 20 years?

☐ Do you live in the GTA such as in Toronto, Mississauga, Brampton, North York Scarborough, etc.?

☐ Are you between the ages of 28-50+?

This study has received Ethics approval from the UT Ethics Board. I encourage you to contact the Board to clarify your rights as a participant in this study at: Tel: 416-946-3273; email: ethics.review@utoronto.ca.
I look forward to hearing from you.

With kind regards,
R.C. Sinclair, PhD Student
Ontario Institute for Studies in Education
University of Toronto, 252 Bloor St. West, Toronto, Ontario M5S 1V6

PS: Please feel free to circulate this invitation to other IMDs whom you believe might be eligible for this study.
Appendix F: Demographics

To begin, I would like to get some short background information on you. Remember that you do not have to respond to a question if you feel you don’t want to. These questions will help me understand and contextualize the data more clearly.

1. Gender: Male □ Female □
2. Age: 28-35 □ 35-40 □ 40-45 □ 45-50 □ 50+ □
3. What is your country of birth: ____________________________?
4. What year did you arrive in Canada: ________?
5. Do you live in the GTA/Ontario? Yes □ No □
6. What year did you obtain your MD degree/equivalent? ____________
   a. How long was your MD degree/equivalent program: ____________?
   b. From which University: ________________________________
   c. From which Country: _____________________________
7. Did you receive additional Postgraduate year training? Yes □ No □
   a. If yes, how many years? _____
   b. What is your medical specialization? ________________________
8. Did you practice clinical medicine before immigrating to Canada? Yes □ No □
   a. If yes, for how long? ____________
Appendix G:
Interview Questions
*(face-to-face informal conversational interview, with probes as necessary)*

**Interview Questions** with PROBES

**Personal Inspiration:**
1. Please tell me a little bit about yourself and what inspired you to immigrate to Canada.
   a. Job, family, family already here, economic advancements?
   b. What have you done since you came to Canada to settle self, family, career?
   c. What are you doing currently?

**Rejection/expertise:**
2. In light of the doctor shortage situation in Canada, what does it mean to you as a trained medical doctor, to not be able to fill that vacancy gap?
   a. How do you interpret this denial of your professional credentials and/or work experience by the Canadian medical professional bodies?
   b. What training/education do you feel you would have needed to help you prepare to practice medicine in Canada?
   c. Do you feel you bring specific expertise that you could contribute to Canadian medicine if you were given the opportunity to do so?

**Life Experiences/trajectories after denial:**
3. How does not being able to continue a career in medicine affect your life as a new immigrant to Canada as:
   a. A **Professional** doctor – physically and emotionally because you can’t:
      1. Work as a doctor
      2. Care for patients
      3. Use or improve your expertise
      4. Upgrade your skills and do what you want to do best
      5. Find suitable employment?
      6. Help your family
         - What are your thoughts currently about your professional achievements in Canada?
         - How important is it for you to pursue a career in medicine in Canada?
         - What does “professionalism” means to you?
   b. **Personal/family** – as a single professional/parent/spouse/son/daughter/in-law, etc., in Canada?
      - What did you expect will happen when you arrive in Canada with regards to settling in a new country, finding a job, economic survival, etc?
      - What has life been like for you and/or family (if applicable) since you came to Canada?
      - To what extent, if any, does not being a “doctor” in Canada bothers you and/or your immediate or extended family?
- If you were to compare a “typical” day/week of your life back home to a day/week in Canada as your new home (besides the cold weather!), but more as lifestyle, how would you describe it?
- How satisfied, or not satisfied, do you feel with the way your life has been since you arrived in Canada with regards to caring for yourself, family, thinking and planning for your future, securing a steady employment?
- Canada is a multicultural country that welcomes new immigrants, how do you feel about this?
- If there was one thing you would like most to be able to do as a new immigrant in Canada, what would that be?
Appendix H:
Kenya International & Intercultural Course and Conference Activities

Joint OISE/Embu University
Exploratory International Summer Course & Conference

Course: The International Conundrum of Food in the Globalized World:
A Social Justice Perspective

&

10th Annual Decolonizing the Spirit Conference
Embu University College and University of Toronto
Kenya, Africa

Professor Njoki Wane
Ms. Cindy Sinclair
Department of Social Justice Education
OISE, U of T
June 28 – July 25, 2016

Eastern Africa
Appendix I:

Embu Community Centre X-Ray Department, Embu, Kenya

Appendix J:

Embu Community Centre Pharmacy, Embu, Kenya

Appendix K:

Embu Community Centre, Embu, Kenya
Appendix L:
IMDs Professional Development Confidence Building Forum

SPECIAL EVENT
Friday, September 18, 2015
6:00-8:30 pm
Confidence Building & You
Iceberg of Human Behavior: Confidence Building & Integration

Higher Educational & non-clinical opportunities

Refreshments & Networking

Healthforce Ontario

Enterpreneurship in Toronto - Opportunities, Resources & Support Networks

Iceberg of Human Behavior: Confidence Building & Integration
Diane Kawarsky, MA
President, The Soft Skills Group Inc

FREE

RSVP: imd2015@gmail.com

VENUE: OISE, U of T, 252 Bloor St. W
(St. George Subway, Bedford & Bloor exit) – public parking

ORGANIZERS: Cindy Sinclair, PhD Candidate, Social Justice Education, OISE
Dr. Rashid Haq, Director of Oncologist, St. Michael’s Hospital

SPEAKERS: Diane Kwarsky, President, The Soft Skills | Dr. S.A. Gulasingam, Resident in Physiotherapy | Emma Johnson, Healthforce Ontario | Sarita Vera, Immigration Newcomer Centre, YMCA | Alexis Dean, Dovetail Marketing & Enterpreneurship