CREDENTIALS RECOGNITION IN MEDICINE

History, Progress and Lessons

ABSTRACT

This article outlines the process for verifying the credentials of International Medical Graduates. It describes the role of governments, of credentialing bodies, and the graduates themselves. It describes the objectives of the newly created Physician Credential Registry of Canada and ends with some "lessons learned."

In 1964, I was one of about 800 Canadian medical graduates. My Canadian medical degree from Dalhousie University, a pass mark on the Medical Council of Canada Qualifying Examinations, and a certificate of satisfactory internship from the medical regulatory body in Nova Scotia would give me access to licensure or post-graduate training within Canada. During the mid- to late-1960s, approximately 1,500 internationally trained physicians (International Medical Graduates or IMGs) arrived each year in Canada. Once their medical degree was recognized by one of the medical regulators in Canada, they too had to meet the same standards. Often they required additional training to meet the internship requirement or other requirements of the Royal College of Physicians and Surgeons of Canada, but at that time – when Medicare was just emerging – there were a relative plethora of post-graduate training posts. In other words, access to those educational opportunities was relatively easy, compared to today. Moreover, when graduates of Canadian medical schools entered post-graduate training or practice, it was likely that the medical graduate working on their left and their right would, on average, both be IMGs!

I tell this story as contrast to the situation in Canada today and to outline why an informal system that seems to have worked for IMGs (and for Canada) in the 1960s has, in the last 10 years or so, come to be considered a major challenge for IMGs. This article will describe the elements of credential recognition for medical doctors and will clarify how the process works for all physicians, regardless of where they trained. However, I will begin by describing the role of the federal, provincial and territorial players in the credentialing process. As we move through this discussion, it is critical to remember that education and health, including medical licensure, are provincial and territorial responsibilities as outlined in the *Constitution Act*, 1867.

The players in the credentials world

There are a number of players involved in the recognition and issuing of medical credentials in Canada:

1. At the provincial and territorial levels, the individual medical regulatory bodies, often referred to as MRAs;
2. At the federal or national levels, the two certifying bodies that assess individuals for eligibility to take their certificates in either family medicine (the College of Family Physicians of Canada) or all other non-family medicine specialties like pediatrics or general surgery (the Royal College of Physicians and Surgeons of Canada); and the Medical Council of Canada, which offers the basic qualifying examinations designed to assess the knowledge and skills required of all physicians, whatever their practice profile or specialty; and
3. At the local level, Canada's medical schools undertake educational processes and issue judgements of performance at the request of the trainee or applicant. This occurs prior to sitting for the exit examination of organizations such as the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, the Medical Council of Canada or when applying for a license to the MRAS.

MRAs regard the recognition of a credential as a yes-no decision: you either meet the requirements or you do not. Moreover, MRAs do not issue their own free-standing credential, but rather they issue the licenses to practice, which may be unrestricted or restricted in terms of what or where physicians

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may practice. When considering a doctor's application for licensure, restrictions can be applied by the MRAs in special circumstances, but most licenses are unrestricted. To that end, the MRAs may use the credentials of the Medical Council of Canada and the two certifying bodies as all three bodies issue a credential for their specific area of medicine.

The need for integrated actions and policies amongst the responsible players

Collaboration between these bodies is imperative to ensure easy access and effective processes for licensing physicians and, of course, to protect the public by verifying the competence of the applicant physician. This is a relatively easy task for Canadian or American medical graduates as there is a common process for medical school accreditation and similar requirements for post-graduate programs, with few exceptions. Canadian and American medical graduates must complete a series of national exit examinations for which the training requirements are clear, such as the Medical Council of Canada Qualifying Examinations in Canada and the United States Medical Licensing Examinations in the U.S. In both countries, these examinations are recognized by all state or provincial regulators, and all Canadian and American medical graduates who pass these examinations have nationally recognized and "portable credentials." Thus North American medical graduates have a mechanism to level the "credential playing field." In other countries, standardized assessment processes that are validated against actual practice requirements and are reliable in their delivery and accuracy are not typically available. However, it is possible for these graduates to access Canadian assessment processes. The only requirement for IMGs is confirmation that they have graduated from a medical school whose degree is recognized for licensure in the country in which it was obtained. This is important, as the quality of medical schools varies, and it is not possible for Canadian agencies to visit all of them to evaluate their standards. For example, there are thought to be over 80 medical schools in Mexico, but there is no national accreditation process or even a registry of these schools. This story is repeated throughout the world.

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Thus, in Canada, like in the U.S., we accept a degree from any medical school that is designated as valid for licensure in the country in which it was obtained, independent of how each country determines this validity. Two sources are used to evaluate whether or not a medical is designated for licensure: the World Health Organization's list and the International Medical Education Directory (IMED), an agency of the Educational Commission for Foreign Medical Graduates (ECFMG) in the U.S. Documents must also be verified by the medical school that issued them, which is called primary source verification, and is an important step as technology can easily be used to create fraudulent documents with the institutional title and official signatures all appearing to be valid. Once the medical degree is validated, existing processes are used to assess the ability and competency levels of all IMGs as is done with Canadian graduates; the same approach is used in the U.S. In short, we accept the medical credential of the school, verify that that document is valid and then assess the individual's level of competence and performance for licensure by our national assessment methods and processes. This approach was reviewed by the National Task Force on the Licensure of International Graduates (Task Force on IMGs) in 2004, and approved by the federal, provincial and territorial Deputy Ministers of Health in the same year. The recommendation was subsequently supported in a report to Health Canada by the National Assessment Collaboration in 2005.

The Medical Council of Canada: current developments facilitating credentialing processes in Canada

In the last three years, the Medical Council of Canada (MCC) has been a major player in implementing specific recommendations of the IMG Task Force. These developments have been supported in part by the MCC, but also by funding from Human Resources and Social Development Canada (HRSDC) and Health Canada. Here I will focus on the credentials aspect primarily but I will briefly mention two other HRSDC-funded initiatives designed to facilitate the assessment of applicants' credentials overseas.

As noted, the purpose of primary source validation is to confirm, with the granting medical school, that the applicant is a graduate of the school and has an authentic document. If this is not possible, then other more time-consuming means are used to verify the applicant's standing. The IMG Task Force suggested that unless the applicant is a refugee, verification should be done prior to arrival in Canada. In the U.S., this verification is executed while the IMG is still off-shore, which can avoid several problems or delays for both parties.

For the past 12 years, the MCC has been the main source of initial credentials verification in Canada. The process begins when the IMG applies to take the Evaluating Examination (EE). The EE was created in 1979 at the recommendation of a national medical workforce coordinating committee. It was intended to be given abroad, before immigration, in order to assess the applicant's general knowledge of medicine independent of Canadian peculiarities, such as laws or culture. Initially, the EE was given in embassies or in other settings overseas (in up to 26 sites at its peak), and embassy and foreign affairs staff oversaw the exam. Cutbacks ended this arrangement, and candidates began taking the exam once in Canada. That meant that

IMGs – some with weaker abilities – were in Canada before any assessment of their credentials or basic medical knowledge had been conducted.

Some larger MRAs carry out their own basic medical degree credential verification, but smaller bodies depend on the MCC to do that job. The IMG Task Force found that the repetitive verification of the medical degree by different bodies increased the cost and delays in accepting IMGs in Canada. Even after an IMG had validated documents and had passed the various required examinations, on applying for licensure in another province or region, the IMG's medical degree again underwent verification. The IMG Task Force recommended a single national agency to carry out the verification. With the permission of the applying physician (to meet privacy requirements), the verification confirmation could be submitted electronically to other requesting bodies. Based on this recommendation, HRSDC awarded a grant to the MCC and its partners to develop a software system to enable e-verification processes, as well as to create a single national agency to verify medical graduates' credentials. The MCC, with the Federation of Medical Regulatory Agencies of Canada (FMRAC), then took steps to establish the Physician Credentials Registry of Canada (PCRC) in 2006.

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Why a new body? The evolving role of the Physician Credentials Registry of Canada

The PCRC will use the e-verification software to establish a one-stop single source verification process. With time, it is hoped that all bodies requiring primary source validation will turn to the PCRC, thereby reducing duplication but also permitting almost instant availability of this verification at the request of the IMG. Secondly, the IMG will now only need to pay once for this verification.

Work is now underway to introduce and promote this service into the processes of each agency. The MCC is to be the initial user and, by the end of 2007, it is expected that the MCC will no longer be carrying out independent verifications, but rather using the e-verification software and the services of the PCRC. MRAs will be targeted, as well, and one has already committed to commence using the PCRC this spring; others are expected to follow shortly. Similarly, the College of Family Physicians of Canada (CFPC) is preparing to do so later in 2007. It is expected that the PCRC will not be independently financially viable for two years, but by virtue of the agreement between HRSDC and the MCC, the software used in this approach will be available to other professions.

A second phase of the PCRC's evolution will be to introduce this service to Canadian graduates. When Canadian medical graduates move, they must submit their documents, including subsequent credentials, such as their Royal College or CFPC certification documents, to the local regional health authority or the local hospitals. If they are moving to another province or territory, all of these documents are submitted to the MRA. If the physicians were to deposit all their verified credentials with the PCRC, they would only need to ask that the PCRC forward an e-verification of their credentials to the requesting body. According to a survey of physicians who had recently moved, their move resulted in them having to submit these documents for verification an average of five times to various bodies before they could be licensed, receive a staff appointment at more than one hospital or clinic or an assignment to a health region, or even to respond to an emergency status in a neighbouring town or city. Thus the PCRC would not only be a credential verification agency, but also a repository of the medical credentials of each physician qualified to practice in Canada. In my lifetime, I have worked in four provinces and one territory, and held staff appointments in five or six different hospitals. The PCRC would have saved me much time and effort, in addition to ensuring the physical safety of my medical degree.

Lessons: where more action is needed

This summary covers a multitude of situations and challenges, both at the national and local levels, which have been faced by the PCRC and the MCC over the past two years. To conclude, I would like to offer a few "behind the scenes" observations and lessons. There is much "tilting of windmills" and pointing of fingers about our credential recognition process, rather than constructive exchange to arrive at a more sensible and smoother process. This is critical because as Canada will continue to be IMG-dependent, particularly in rural or more isolated areas, so solutions are needed. Below, I offer my "top" lessons:

1. Cooperation is required especially in a system where credential recognition and licensure in the field of medicine happens at the federal, provincial and territorial levels. The report of the Task Force on IMGs focused on what to do rather than what not to do, but many still emphasize barriers. Quality assurance and continuous quality improvement should not be considered as barriers, but part of a constructive process to improve outcomes for the public;

2. There is a myth that the failure to recognize credentials is preventing IMGs from accessing post-graduate training or work. This is only true for a small number of IMGs. Over 95% of IMGs will have their basic credential – the medical degree – recognized. Nonetheless, there are a lack of transition courses for

IMGs, which can prevent them from succeeding in the other assessment processes, and while more provinces are offering transitional programs, provincial ministries of health still carefully control access to post-graduate residencies slots;

3. Findings of the IMG Task Force, as well as one-on-one interviews with IMGs, suggest that IMGs who are experiencing difficulty tend to fall into three groups:

    a. Those IMGs who choose to defer getting further training and let their skills lapse or decrease. This may be a result of personal conditions and is a decision that is not necessarily based on expert advice. These IMGs need "bridging advice" as soon as they arrive;

    b. Those IMGs who are plainly under-qualified due to inadequate assessment prior to immigration. The Evaluating Examination should be used as it was intended in 1979: administered abroad and with the input and collaboration of the departments of Immigration and Health;

    c. Those IMGs who choose to reside in the larger cities where they may be professionally disadvantaged because of competition and fewer job openings. They need advice about where they can expect to find opportunities. Bridging processes are also needed along with a realistic assessment of work and training opportunities prior to departure to Canada;

4. We need to create inter-departmental interfaces to better plan where IMGs are needed and to link recruitment and assessment processes before they arrive, with the offer of transitional and bridging processes once IMGs are here. There is no free-market for physicians in Canada: under the *Canada Health Act*, the provinces are in charge of paying physicians and control access to further education. It is what economists would refer to as a "monopsony," a market situation in which there is only one buyer. There are no free-standing clinical programs to offer preparation, like an MBA in the world of business. IMG applicants should be required to submit to credential verification with the PCRC before receiving points for their education or experience on their application for immigration to Canada. Indeed, the MCC now offers on-line self-assessment tools in an effort to implement the IMG Task Force's recommendation to conduct off-shore credential verification and assessment of basic knowledge and skills prior to immigration. By 2008, the MCC will be offering computer-administered screening exams around the world, thanks to developmental support from HRSDC.

A personal wish or two

I began this article with my story about the 1960s, and one could ask "What went wrong?" It seemed so much easier for IMGs then. In my opinion, three factors can help explain our current situation. First, in the 1960s, most physicians came from countries with education systems similar to that in Canada, such as the U.K. or Ireland. Because the systems were similar, these IMGs were, in a sense, pre-screened, and they had a relatively easy transition, educationally and culturally. Today, IMGs come from a wider range of countries, including those in Asia and Eastern Europe, which can make this transition more difficult. Secondly, there was much flexibility in the 1960s with respect to the assignment of training opportunities, which provided IMGs with a range of training choices and posts. Finally, the medical profession was accustomed to the arrival of many IMGs and helped them become established. Today, many teachers and physicians – who are already experiencing overwork – see the arrival of IMGs as an imposition because of the additional education needs that poorly screened or unprepared physicians may have. We should use the excellent tools we have and carry out more valid assessment of applicants to prevent poor selection. We must inform IMGs that validation of the medical degree is only a starting point. With better team work – and that means candor – and bridging plans for all skilled professionals, it is possible to help initiating parties, the federal government and the IMGs be better prepared.