To a large extent, immigration to Canada means locating in one of the major urban centres (particularly, Toronto, Vancouver, Montréal and Ottawa). Typically this is where a newcomer to Canada will find the best employment opportunities. Furthermore, there are often well established ethnic networks that help new immigrants get settled. However, for physicians and particularly those who practice family medicine, the likely destination for a first job is a rural and often remote community.

This article describes the experience of the province of Newfoundland and Labrador (N.L.) with international medical graduates (IMGs), covering the recruitment and retention of physicians and summarizing the results of a survey of 1,160 physicians who practiced in the province over the period 1995 to 2004. Conclusions from the summary may provide useful information to improve future recruitment and retention practices.

The practice of medicine in each province is governed by a provincial college of physicians who award licenses to individuals with suitable qualifications. The most common qualification is being a fellow of a Canadian College of Physicians, such as the College of Family Physicians of Canada (CFPC). Typically, entry into a Canadian College requires the successful completion of a series of examinations and some time in practice in Canada. For the CFPC, two years of practice in Canada is required for entry. All provincial colleges allow individuals to practice without membership in a Canadian College; however, they are awarded a “provisional” license (rather than a “full” or “regular” license). Most physicians who practice under provisional license are graduates from a medical school and have practiced medicine outside of Canada. Physicians who were trained outside of Canada are generally referred to as International Medical Graduates (IMGs).

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The provision of health services in Canada is, by and large, coordinated through an individual’s family physician (or general practitioner). Recent evidence (e.g. Sullivan 2006) demonstrates that fewer and fewer medical school graduates are choosing family practice as their choice of residency. Those who do choose family practice tend to be much more likely to prefer living in urban areas. This makes the provision of primary health care particularly difficult in rural and remote communities. Increasingly, rural and remote communities are turning to International Medical Graduates (IMGs) to fill the void.

Audas, Ross and Vardy (2005, 2006) examine the use of provisionally licensed IMGs (PLIMGs) in the delivery of medical services across Canadian provinces and find that the patterns differ considerably. Some provinces make very little use of PLIMGs (such as Ontario, Quebec and New Brunswick) while others, notably Saskatchewan and Newfoundland and Labrador, rely heavily on them.

Figure 1 shows how the use of PLIMGs varies across provinces.

As Figure 1 highlights, PLIMGs make up a greater proportion of the physician workforce in N.L., compared with any other Canadian province. As will be described below, this creates a challenge for communities because PLIMGs tend to stay in N.L. for a relatively short period of time, requiring communities to put forth an ongoing recruitment effort that is costly and disruptive to them.

**Physicians practicing under provisional license in Newfoundland and Labrador**

Many communities in N.L. have difficulty retaining physicians, and PLIMGs play a critical role in providing primary health care in these communities. Typically, the communities that struggle to attract and retain physicians are rural, remote and often economically depressed. Since they serve relatively small populations, they are not viable locations for a fee-for-service practice, and, as such, most physicians practicing in these communities are paid on a salary basis.

Anecdotal evidence suggests that a significant proportion of the PLIMGs practicing in N.L. tend to remain in the province only until they successfully complete their licensing exams, before leaving for a potentially more lucrative practice in a wealthier province. This has created something of a revolving door in many communities with physicians staying only long enough to complete their exams.
enough to obtain entry into a Canadian college, then departing. It has also been suggested that some PLIMGs do not successfully complete their exams after two years, yet remain in practice in N.L. The concern is that rural Newfoundlanders and Labradorians are facing an unfair situation, one with high physician turnover and potentially having care providers who have not successfully met Canadian licensing standards.

In N.L., physicians practicing under provisional license are largely unrestricted in their practice – they fill an important shortage, and, without them, many communities would have no immediately accessible physician. As part of their employment contracts, the physicians are normally given time to prepare for their College exams. After two years of practice and successful completion of College exams, many PLIMGs (who would now be eligible for a full license in any Canadian province) relocate.

N.L. has a long history of using IMGs, although the origins of IMGs have changed dramatically over the past two decades. Previously, IMGs practicing in N.L. generally came from the British Isles; however, increasingly, they are coming from developing countries. Figure 2 breaks down the country of origin of PLIMGs practicing in N.L. from 1995 to 2004.

Figure 2 indicates that more than 57% of the PLIMGS came from sub-Saharan Africa (mainly South Africa) and the Far East (mainly India, Pakistan and Sri Lanka). A relatively small proportion came from the Americas and Europe.

Figures 3 and 4 detail the current situation with PLIMG utilization in N.L.

Figure 3 shows that the PLIMGs practicing family medicine in N.L. tend to be much more likely to be concentrated in rural locations. As of June 2007, out of a total of 105 PLIMGs practicing as family physicians in the province, 93 were outside the main urban centres of St. John’s/Conception Bay South and Corner Brook.

Figure 4 shows the overall pattern of PLIMG utilization year on year, with the clear trend being an increased reliance on immigrant doctors to provide medical services in the province. Audas, Ryan and Vardy (2007) show that the retention rates of PLIMGs is very low, with only one in five staying in the province longer than five years. Replacing physicians is costly and tends to result in lower satisfaction as patients are unable to build up a long-term rapport with their family doctor.

One way in which this issue could be redressed is by improving retention of IMGs who practice in N.L. under provisional license. To examine ways in which this could be done, we conducted a survey of PLIMGs who practiced in this province between 1995 and 2004. There are two
fundamental ways in which we see better retention being achieved. The first is through making a better initial match between the physician’s background and the location where they practice. The second is by the province, health authorities and communities doing a better job creating the conditions that would promote retention. Again, anecdotal evidence suggests that many IMGs choose N.L. because there is an availability of jobs and a willingness to let physicians practice under provisional license.

The survey was designed to help find avenues to improve retention. With permission from the College of Physicians and Surgeons of Newfoundland and Labrador, data were obtained for all physicians who practiced under a provisional license within the province during the years 1995 through 2004. The questionnaire used in the survey and the assessment of the full survey results are described in our 2007 article on the Harris Centre website at www.mun.ca/harriscentre.

**Survey findings**

We received responses from 200 physicians, 52 of whom were still practicing in N.L. and 148 of whom have relocated to other parts of Canada. We have separated responses for those who are currently practicing in N.L. and those who are practicing in other parts of Canada. The broad objective is to identify characteristics that are most associated with the decision to remain in, or migrate from, N.L.

The age distribution of respondents does not reveal any striking differences in terms of those who stay and those who leave N.L., although it appears that those who remain tend to be more likely to be at the extremes of the age distribution (either less than 40 or 50+). There is evidence suggesting that as physicians’ children reach their teen years there is a tendency to move to more urban locations to provide more opportunities for their children (e.g. a greater variety of extracurricular activities that may be unavailable in more rural and remote communities).

The vast majority (88%) of PLIMGs come from medium (50,000 to 500,000) or large cities (Over 500,000). Interestingly, and perhaps counter-intuitively, those staying in N.L. tend to be more likely (94.2%) to come from medium to large cities compared with those who left the province (83.1%). The evidence does not support the conventional wisdom that those who come from large cities tend to be more likely to wish to practice in similarly urban communities.

The vast majority (88%) of PLIMGs are male, with a slightly higher proportion of males choosing to remain in N.L., compared with females who practice in N.L. This is in contrast to the current trends among Canadian medical graduates, the majority of whom are female with females also being more likely more likely to practice family medicine (Canadian Residency Matching Service 2007).

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PLIMGs practicing in N.L. tend to be married, although those who were single before coming to the province tended to be more likely to remain here. There is evidence that one of the main concerns of physicians practicing in rural
N.L. is that there are inadequate opportunities for their spouses to pursue their careers, suggesting that a subsequent move to a more urban community is driven by a lack of employment opportunities for their spouses (see Mathews and Mayo 2006).

The issue of lifestyle marked a significant contrast between those who decided to remain in the province and those who migrated, with 20% of all PLIMGs reporting that the lifestyle in this province appealed to them. Those who remained in the province were 2.5 times more likely to indicate that the lifestyle appealed to them than those who had not selected lifestyle.

We asked how many had undertaken a site visit prior to making their decision to relocate to N.L. Few PLIMGs reported that the decision was driven by a positive impression based on a site visit.

Very few PLIMGs choose to practice in N.L. for monetary reasons. However, those who did were almost twice as likely to migrate. This is not surprising, since those who are motivated to practice here for financial reasons would be more likely to be enticed away by practice opportunities (in Canada or elsewhere) that can offer greater financial rewards.

The most common reason why PLIMGs chose to practice in N.L. was the opportunity to become fully licensed. There is a striking difference between those who remained in N.L. and those who relocated out of the province, with those who left being far more likely to indicate that the opportunity to become licensed was a primary reason for choosing to practice in N.L.

Relatively few respondents indicated that career opportunities for spouses were a significant factor in their decision to practice here. However, individuals who identified this as an important reason for their decision to practice here were 2.5 times more likely to remain here. This suggests that in those situations where good opportunities are available to the PLIMG’s spouse, the likelihood of retention is much greater.

The majority of physicians practicing in the province tended to bring their families with them when they began their practice here; those who did were slightly more likely to move to other parts of Canada than those who did not.

A significant proportion of individuals who chose to practice in N.L. did not receive an orientation in any of the locations in which they worked. However, those who did receive an orientation were much more likely to continue to practice in N.L. A good orientation program for new physicians would appear to be an excellent investment in terms of encouraging better physician retention.

Most of those receiving orientation did get exposure to the facilities, rules and requirements. Furthermore, those receiving this exposure are more likely to continue to practice in N.L. This supports the evidence that a good orientation to how medical practice works in N.L. should help improve retention.

Those who were oriented to CME and other personal learning needs were more likely to remain in N.L., suggesting a role for CME in terms of promoting physician retention.

Relatively few physicians had problems with the licensing or immigration process; however, those who did were more likely to remain in N.L. This may be a result of fatigue with the licensing and immigration process or it may suggest that those who had difficulties were more likely to have difficulty subsequently relocating within Canada.

Few individuals reported that children’s involvement in extra-curricular activities helped build their community network. However, those who did were more likely to relocate. This, perhaps, reflects the anecdotal evidence described earlier, whereby physicians with children entering their teen years are more likely to subsequently migrate to allow their children a wider range of extra-curricular activities.

The most common reason indicated for leaving was dissatisfaction with pay. It should be noted that physicians working under provisional licenses are almost always paid a salary and N.L. is the only province to have a significant proportion of its family physicians paid on a salary basis (as opposed to being paid based on a fee-for-service basis). Physicians who relocate would undoubtedly convert to fee-for-service and would have the opportunity to increase their earnings, albeit with a higher workload.

The next most common reasons indicated for relocation were dissatisfaction with social networks and the desire to live in a community with individuals of a similar cultural background to their own.

It appears that the relocation of physicians out of the province is part of the larger trend towards increasing urbanization in Canada, with 80% of those migrating from N.L. residing in medium or large cities.
Conclusion
Perhaps not surprisingly, the survey results do not reveal any single dominant factor associated with the decision to stay in N.L. or to relocate to practice elsewhere.

Physicians who remained in N.L. tend to come from larger cities and tend to be single and male. They also tend to be either relatively young or more senior, suggesting that recruitment targeted towards these demographic groups could result in better initial matches in order to encourage retention.

In terms of practices, a good orientation program (and perhaps additional orientation for spouses) is likely to encourage retention. While there was no overwhelming reason provided for relocating out of the province, the most cited reason was dissatisfaction with pay. Furthermore, a sizeable number of individuals reported being dissatisfied with their social networks, and a similarly sizeable number of individuals reported wanting to have more interaction with individuals from the same cultural background. While very little can be done about the latter, it does suggest that if communities are better able to reach out to PLIMGs, they will improve the likelihood of retention. There also appears to be an increased role for continuing medical education (CME). Many of the individuals practicing in rural and remote communities will undoubtedly feel a sense of social and professional isolation. A more active CME program accompanied by a tailored program to facilitate professional development could help reduce this isolation.

There is some evidence that those who relocate to N.L., because it is relatively easy to sort out immigration and licensing, are more likely subsequently to move. This raises a larger issue about the role of this province in terms of recruiting physicians and subsequently screening them for re-deployment throughout Canada and the incidence of the costs associated with this in comparison with the benefits received to the recruiting province.

References
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In a health care setting, cultural competence is often viewed as a responsibility of the health care provider. As such, the contextualization of cultural competence within a tri-partied perspective of the individual (patient), the health care provider and the service sector (health care system) tends to be seriously overlooked. This is a particularly pertinent issue in Canada, due to the country’s stance on human rights, diversity and multiculturalism issues. The Canadian Charter of Rights and Freedoms protects individuals’ rights and privileges, and the Canadian Multiculturalism Act promotes practising religion and cultural rituals while encouraging Canada to become a multicultural mosaic. This differs significantly, for instance, from the American model of a “cultural melting pot.” Therefore, meeting the demand of culturally competent care is a far more complex task in Canada than in the United States.

Within Atlantic Canada specifically, the demographic landscape is rapidly becoming more diverse due to an attraction to the region by a large variety of cultural, racial/ethnic and linguistic communities across the globe. Consequently, providing culturally competent health care to ensure equity and justice creates increasing challenges to health care providers. The Atlantic cultural fabric includes Canada’s First Nations peoples, Acadians, African Nova Scotians and immigrants from non-English speaking Asian and European countries. Each Atlantic cultural community brings several different religious perspectives, including various Catholic denominations, sectors of Buddhism, Islam and Hinduism, as well as other faiths such as Bahá’í. Language can also be an issue with respect to cultural competence in the Atlantic provinces. In Nova Scotia, for instance, French has long been the second most prominently spoken language after English, although recent demographic landscape shifts have now moved Arabic to second place (Statistics Canada 2007). New Brunswick holds the distinction of being the only bilingual province in Canada. One of the contributing factors for acculturation to the health care system is social capital (Wu 2004). Atlantic cities face greater challenges in acculturating immigrants to the Western health care system due to the social isolation created by having fewer number of immigrants within a cultural group classified by language, race/ethnicity and religion, compared with Canada’s urban cities of greater immigrant concentration such as Montreal, Toronto and Vancouver.

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