Internationally Educated Health Professionals in Nova Scotia: Why They Come, Why They Stay and the Challenges They Face

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February 10, 2008

□ 2008 Patricia Saunders for IEHP Atlantic Connection

ISBN:

The Internationally Educated Health Professional Initiative is a Health Canada project mandated to deliver on the First Ministers Ten Year Plan; a commitment to reduce wait times and increase the supply of health professionals to the Canadian Health Care system. The federal government committed $75 million in its 2005 Budget over five years (2005/06-2009/10) to support provincial and territorial activities that will permit IEHPs to integrate into the Canadian workforce.

The **IEHP Atlantic Connection** Internationally Educated Health Professionals (IEHP) has been underway in Atlantic Canada since May 2005. Through IEHPI, Health Canada is providing funding to the Departments of Health of the four Atlantic Provinces for a number of collaborative projects.

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This Report has been prepared for IEHP Atlantic Connection

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Acknowledgments

A number of organizations and individuals provided generous support and assistance during the course of this research project. Special thanks go first to all the internationally educated health professionals in Nova Scotia who took the time to share their experiences of the challenges they face coming and staying in the province. Special thanks as well to the other members of the project research team for their collaboration at each stage of the research, particularly Godfrey Baldacchino for initiating and co-ordinating our work.

The Metropolitan Immigrant Settlement Association provided invaluable aid in recruiting survey participants for which I am very grateful. I am also grateful for the assistance of Dianne Silver Smith, Post Graduate Medicine, Dalhousie, Gwen McPherson CAPP, Anne Chipman,CPSNS, and Megan Edwards at the Office of Immigration, NS, all of whom took the time and trouble to provide advice and access to needed information. To Dr. Robert Maudsley, CAPP I owe a large intellectual debt. Without the benefit of his knowledge and insight, generously shared through many discussions, my understanding of the issues involved in the assessment and re-certification of internationally educated health professionals would be much poorer.

Finally I would like to extend my thanks to Jennifer Murdoch, Department of Health NS, both for her inspiring brainstorming sessions and the opportunity to work with the IEHP Atlantic Project; Michelle Hood, Coordinator IEHP Program, PEI and Pillar Lead, IEHP Atlantic Connection for her always good humored and insightful conversations; and Terry Murphy at Adult Education Supply House and June MacDonald at Price-MacDonald and Associates Consulting Ltd. for their continued support of this research project.

Executive Summary

This section summarizes the main findings from the report entitled *Internationally Educated Health Professionals in Nova Scotia:Why They Come, Why They Stay and the Challenges They Face.* Interested parties are encouraged to review the full report for a more detailed account of the research project.

Background:

In September of 2004 the Federal government and the provinces and territories signed a First Ministers 10-Year Accord agreeing to accelerate the workforce entrance of internationally educated health professionals (IEHPs) in order to address shortages and reduce waiting times for health care. Part of a new effort to develop a pan-Canadian approach to health human resources planning, the recruitment, retention and integration of IEHPs was identified as a means of achieving several strategic goals: increasing the cultural diversity of health care providers to "reflect the Canadian mosaic"; increasing supply of health care providers to ensure availability when and where needed, and improving utilization and distribution of existing health care providers (including IEHPs). At the same time IEHPs have experienced many challenges to integration into Canadian health professions. In recognition of these challenges Health Canada launched the Internationally Educated Health Professionals Initiative (IEHPI, 2005) whose aim is to reduce barriers so that a greater number of IEHPs can be assessed and integrated into the health care system. A task force addressing the integration of international medical graduates (IMGs) had been struck earlier in 2002.

Through the IEHPI Health Canada has entered into partnerships with the provinces to increase the integration of IEHPS focusing on 7 professions which include: medicine, nursing, medical laboratory science, medical radiation technology, pharmacy, physiotherapy and occupational therapy. In Nova Scotia various projects are now underway to increase support for IEHP integration, funded by IEHP through the IEHP Atlantic Connection. This research study is one of those projects and forms part of a regional research collaboration to address the attraction, integration and retention of IEHPs to Atlantic Canada. The study was conducted though a web-based survey during 2007 and focused on eliciting the stories and experiences of IEHPs in re-locating and integrating to the health professions in each of the four Atlantic provinces.

Summary of Major Nova Scotia Findings:

IEHPs are attracted to Nova Scotia for the quality of life offered by the province, the educational opportunities available and by what they perceive to be its promising health professional employment prospects. In fact, at least 50% of those who responded to the survey were either unemployed or under employed at the time of the survey and only two of these were actively engaged in pursuing re-certification.

This research identifies and clarifies the range of challenges IEHPs experience within Nova Scotia in gaining re-certification including, lack of sufficient information about the re-certification process, limited access to assessment and subsequent bridging and/or training opportunities, lack of academic support for preparing for assessments and qualifying exams, difficulty finding employment in health care related work in order to gain necessary Canadian experience, and the financial costs and length of

time required to complete the various stages of re-certification. The survey respondents identified the same challenges as obstacles for future attraction of other IEHPs to the province. In addition to these they cited further obstacles to recruitment as the lack of cultural diversity, cost of living, and cost and difficulty of travel in and out of the province.

Despite all of these barriers most of the respondents indicate their intention to stay in Nova Scotia and the majority indicate that living in the province has been a positive experience. This would suggest that if access to re-certification and support for professional integration support were to be made more available greater numbers of IEHPs would be attracted to, and retained by the province. The need for assessment, training and support programs is acute and occurs across health professions at every level. At the same time the numbers of IEHP clients for such programs is small creating challenges for funding program development and long term sustainability. IEHPs are most often recruited for under-served locations and their long term retention is a further challenge and one that is receiving little attention.

Main Recommendations:

Finite resources make it necessary to prioritize which levels of program development, and in which health professions, will receive resources.

Better information about the numbers, and level of progress toward licensure, of IEHPs now residing in the province and region is needed. Improved data collection procedures need to be developed and implemented.

In light of competition with other regions, and of the rapidly developing movement toward national standardization of assessment and licensing procedures to increase IEHP mobility within the country, the Atlantic provinces must collectively commit to a regional strategy. No one province has the numbers of IEHP clients, nor the program capacity to absorb the numbers that would be needed, to mount and sustain IEHP integration programs across all seven targeted professions.

The Department of Health should support further IEHP recruitment and retention research, and develop proactive strategies and initiatives for retaining IEHP physicians that target those most likely to stay. The province relies on financial incentives such as alternative payment plans to increase rural retention but research suggests that this may not be the most effective strategy for retaining health professionals in rural and remote locations.

1.Introduction

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

1.1 Purpose of this Report:

This report presents the results of a research study concerning the attraction, integration and retention of internationally educated health professionals (IEHPs) in Nova Scotia. Understanding why IEHPs come and why they stay in the province will aid in program and policy development for reducing barriers to IEHP employment and retention. While there has been a fair amount of research addressed to the role of internationally educated medical graduates in the context of supply and demand in the physician workforce it has been limited in focus to the examination of credentials, competencies, demographic characteristics and distribution across specialties, practice locations, and/or geographic regions. To date there have been very few studies based on the experiences and perspectives of IMGs/IEHPs as they relocate and navigate their way through settlement into communities, the re-accreditation process and entry to professional practice. This research focuses on just such issues in hopes of contributing a more textured understanding of the personal and collective experience of IEHPs in Nova Scotia. It also contributes to Health Canada's Pan-Canadian Health Human Resource Strategy which identifies the reduction of barriers to employment for IEHPs.

1.2 Policy Context:

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

Canada formally recognizes itself as a nation built through immigration, and takes pride in its historical commitment to a " multicultural mosaic" or integrationist approach to the acculturation of new comers. The celebration and promotion of cultural diversity is a matter of public policy in Canada and entails the provision of a range of social and cultural services intended to ensure that integration involves a two-way process of adaptation. The success of this approach rests on the commitment of immigrants to Canadian society and of Canadians to the acceptance and valuing of cultural difference. In theory, then, Canada is a nation more friendly to new comers than assimilationist countries such as its neighbour to the south.

While the public discourse surrounding Canadian immigration has traditionally focused on the innovations and contributions to cultural diversity that immigrants bring to Canadian society, more recently public attention has turned to the role of immigration in meeting workforce shortages. We are a country whose aging population, falling fertility rates and a trend toward fewer working hours and earlier retirement make us increasingly reliant on immigration for sustaining population growth and meeting our current and projected workforce needs. Even though Canada is the second largest country in the world in terms of land mass, it ranks 33rd in terms of population. Twenty per cent, approximately 1 in 5, of Canadians were born in another country, second only to Australia for percentage of the population which is foreign-born, with an annual immigration rate relative to population size that is

now greater than any other country in the world including Australia's.(Canwest News, 2007) The annual percentage of Canadian-born individuals entering the workforce is still currently greater than the number of immigrants entering the labour market, however our domestic supply of workers will not meet future demands and all net labour force growth will come from immigration in 10 years**.**(Statistics Canada, 2007).

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

Professionals are now the largest group of immigrants coming to Canada, with the proportion of those intending to work within *regulated professions* increasing from 16 % in 1990 to 42% in 2000 (CIC, 2003). Unfortunately the dramatic success in increasing the numbers of highly skilled and professional immigrants entering Canada has not been matched with equal success in their labour-market integration. Despite having higher educational and skill levels the unemployment rate of recent immigrants (12%) is nearly twice that of the Canadian-born population (6.4%) and although 80% of immigrants find full time work within two years of arrival, only 42% find employment in their field.(Tocci, 2007) Furthermore the *low income-rate* among new immigrants *rose* from 24.6% in 1980 to 35.8% and has continued to do so since 2000 (Picot,G. Hou, F. Coulombes, S. 2007). In other words immigrant poverty has increased and earnings have decreased over the past two and half decades.

Current research indicates that these dismal labour market outcomes are partially accounted for by economic cycles and the mini-recession effect created by downturns in the high-tech sector.
The shift in source countries of Canada's most recent immigrants has also been identified as a significant factor influencing low income rates and has particular significance in the context of barriers to professional employment. (Picot,G. Hou, F. Coulombes, S. 2007, Saunders, P. 2007b, Schellenberg, G. 2007). Recent professional immigrants face greater language barriers and *far greater national differences* between the *methods and length of education and training programs* and between *professional cultures* than those who entered before the 1990s. As a result their acculturation is more difficult, and their need for assessment, skills enhancement, bridge programs, and training opportunities as prerequisites for integration to employment is greater. Because capacity development and implementation of such transitional supports have been *uneven across the country,* and have n*ot kept pace* with the rising numbers of immigrant professionals migrating to Canada , access to such programs continues to be highly competitive and varies considerably from province to province. The end result is that many IEHPs are left completely outside the re-certification process .This discouraging situation might in part explain why a large percent of immigrants since 2000(67%) who indicate at the time of immigration that they are seeking employment in a health occupation, simply do not apply to have their credentials assessed. after they have arrived..(Statistics Canada, 2007). As Dale Dauphinee has demonstrated, this 'bottleneck' effect is the result of a “failure in corporate memory' that did not

recognize the gap between "federal immigration policy and the restrictive workforce policies of the ministries of health" that left regulatory bodies and educational institutions unprepared for the rapid influx of health professionals whose characteristics and integration needs are very different from those who entered the professions through the 1960s and early 1970s (2006). Of the 33% of professional immigrants to Canada who do have their credentials assessed, 36% were successful obtaining full recognition, while 35% received partial recognition of their credentials.
(Statistics Canada, 2007).

Clearly if immigrants are unable to convert previous training into productive employment then Canadian immigration and human resource development policies will fail to meet the expectations of immigrants and the Canadian public alike. Unsurprisingly there has been no shortage of media coverage of the apparent disconnect between policies which promote a human capital immigration model of further skills enhancement to ensure workplace integration, and the stark reality of highly educated immigrants who find themselves working as cab drivers, or delivering pizza. When the report concerns an individual who is an internationally educated doctor or nurse, the tone is likely to turn from baffled incredulity over the waste of human resources, to anger fueled by public frustration over perceived shortages of health professionals, and growing suspicions of 'creeping credentialism' and turf protection on the part of Canadian health care professions. (Milne, 2003).[1] Nor should it be surprising that political pressure to quickly address the barriers to professional employment for internationally educated health professionals has intensified. Rapid solutions to the problem of professional immigrant underemployment are, however, difficult to achieve, particularly within the regulated professions where complex and interacting jurisdictional roles and responsibilities must come together to create the kinds of systemic change that are required and this is nowhere more true than in the health professions.

Human Health Care Resources and Internationally Educated Health Care Professionals

> *Canada is currently experiencing shortages of many types of health care providers in many regions, or so the media stories would have us believe. Stories of physicians fleeing under -resourced communities, of people even in urban settings unable to find a primary care physician, and of operating rooms closed despite long wait lists because of shortages of skilled personnel. Less immediately visible is the dearth of health professionals serving Aboriginal communities. On top of this, there are increasing numbers of warning about what lies ahead—our aging and demoralized nursing workforce, an aging physician workforce and so on. The stories reported by the media are usually relatively factual, as far as they go. What is seldom clear, is how generalizable they are, or what forces and factors underline the headlines*.
>
> Gail Tomlin Murphy,
> CIHR Science Lead in Health Human Resources, June 2005

1 The public tends to assume that problems of access to primary medical care are the direct result of physician shortages and physicians have done little to dissuade them of this idea. Health Canada introduced an Inter-Professional training initiative at the same time as the IEHPI to address the underutilization of allied health care professionals . Physician buy in to the new Inter-professional initiative has been weak at best. (Church, 2007) For an early, but still relevant discussion of IMGs in the context of Canadian physician supply and the use (and under use) of allied health professionals in the context of professional 'turf protection .' see Evans , 1975.

In September of 2004 the Federal government and the provinces and territories signed a First Ministers 10-Year Accord agreeing to accelerate the workforce entrance of internationally educated health professionals in order to address shortages and reduce waiting times for health care. Part of a new effort to develop a pan-Canadian approach to health human resources planning, the recruitment, retention and integration of IEHPs was identified as a means of achieving several strategic goals: increasing the cultural diversity of health care providers to "reflect the Canadian mosaic"; increasing the supply of health care providers to ensure availability when and where needed, and improving utilization and distribution of existing health care providers (including IEHPs). In 2005 Health Canada announced the Internationally Educated Health Professionals Initiative (IEHPI) whose aim is reduce barriers so that a greater number of IEHPs can be assessed and integrated into the health care system.(Health Canada 2006). A task force addressing the integration of international medical graduates (IMGs) had been struck earlier in 2002.. Through the IEHPI Health Canada has entered into partnerships with the provinces to increase the integration of IEHPs targeting 7 professions which include: medicine, nursing, medical laboratory science, medical radiation technology, pharmacy, physiotherapy and occupational therapy. Various projects are now underway to increase support for IEHP integration at both national and provincial levels, including those undertaken by the IEHP Atlantic Connection.

Also in 2006, Human Resource and Social Development Canada's Federal Credential Recognition Program turned its attention to the health care professions (FCR). The FCR has a mandate of creating a labour market program aimed at effecting *systematic change* by developing a Pan-Canadian FCR capacity that is fair or non-biased; consistent across jurisdictions; transparent so that clients will receive feedback on how credentials were assessed; and rigorous in order to ensure public safety. The program has prioritized the same 7 health professions as the IEHPI, beginning with physicians and nurses. It has also been working with midwives—50% of those licensed to work in Canada are IEHPS-- and cardiology technologists. The focus of their program has been on managing expectations of entering IEHPs by increasing availability and access to pre-immigration information and self-assessment tools; developing bridge to work tools and internships; mounting anti-racism programs; and supporting national and provincial credential review initiatives. (Tocci, 2007)

Real progress has been made, for example the Medical Council of Canada now offers a web-accessible self-assessment tool to IMGs who plan to take the Medical Council of Canada Qualifying Exams (MCCE 1 & 2) and will soon launch a web-based qualifying exam (MCCE) so that IMGS may begin the certification process before emigration. They also are working with the IMG Task Force Two to standardize licensure requirements and assessment tools/ procedures across provincial jurisdictions.**(**Kondro, 2006, Health Canada, 2007). Meanwhile, the Associated Faculties of Medicine has launched a much needed initiative, the Canadian Post-MD Education Registry **(**CAPER) mandated to create an IMG database to provide accurate information about IMGs in Canadian training institutions and the physician workforce. The Canadian Nurses Association has also moved forward with FCR support to develop both prior learning and assessment recognition (PLAR) tools and strategies for assessing Internationally educated nurses (IENs) and a bridge to Canadian nursing educational program.(Hendrickson, B. Nordstrom, P. 2007). Influencing systematic change is a process that moves slowly due to the complexity of the issues and number of stakeholders and jurisdictions involved. Provincial and territorial regulatory bodies are responsible for licensing, and post-secondary education institutions, provincial assessment agencies and employers also share responsibilities for assessment and/or recognition of credentials. Implementation of such change is necessarily the last phase of a lengthy process. It is also the only phase that will improve the situation for any *individual* IEHP or

make measurable differences to health care workforce shortages. For those IEHPs who have been waiting for barriers to professional health care employment to be reduced, and the public at large, it may well appear as though little or no change has occurred.

One final policy issue should be addressed here, that of the ethical recruitment of IEHPs. Canada has always relied on internationally educated health professionals to deal with labour shortages and the maldistribution of human health resources. However, as was noted above, what is different now is that these professionals are increasingly coming from developing countries--mainly Africa and Asia –that can ill afford to lose them. In 2001 South Africa's High Commissioner to Canada publicly criticized Canada for recruiting so many health care professionals from its struggling health care system and Canada agreed to cease active recruitment from South Africa. The issue of ethical recruitment is not a straightforward one. On the one hand are the health needs of developing nations which suffer as global migration of health care professionals in search of better educational and career opportunities increases. On the other there is the right of individuals to move. For Canada there is also the factor of migration of Canadian trained health professionals to the United States, and the persistent pattern of inter-provincial movement of health professionals which creates a greater need for IEHPs in some provinces and regions than others; problems which lead to a tendency to look to developing countries to solve poor distribution problems.(Dauphinee, D 2005, 2006, 2008)

For some time now the discussion of ethical recruitment practices has been largely stalemated between these opposed positions. However as a recent research report discussing the policy options for Canada demonstrates there are paths out of the “maze of conflicting rights.”(Klassen,N., McIntosh, T., Togerson, R., 2007) They suggest as a starting point a consensus that it is unethical for relatively wealthy countries like Canada to recruit IEHPs from developing countries to solve shortages and problems created by either the underproduction or the maldistribution of professionals. Greater efforts to define the meanings of active and passive recruitment are also needed. For example, reliance on “word of mouth” recruitment by communities of health professionals from particular countries has replaced active recruiting and in some provinces is an official policy, but do such practices constitute 'passive' recruiting? They also note that for ethical guidelines and policies to be workable the issue of recruitment will need to be more fully included in the broader context of health human resource planning and call for both federal and provincial response to the issue.

As yet, neither the federal government nor any individual province has developed ethical guidelines for recruitment policies, but the Canadian medical profession has begun to address the issue, suggesting policy choices to assist developing nations alleviate the 'push' factors, such as the quality of educational programs, within their health care systems. and the media have begun to cover the topic.(Norcini, J, Mazmanian P. 2005) Meanwhile the World Health Organization has made a series of recommendations to ensure a global ethics of health care professional migration that includes the suggestion that benefactor nations provide financial compensation to donor nations. Now that discussion of ethical responsibilities has finally begun to move forward it can only be a matter of time until both the federal government and the provinces will need to adopt policies and guidelines for governing recruiting practices.

1.3 Internationally Educated Health Professionals in Nova Scotia: issues and challenges

In 2003 Nova Scotia's Department of Health mounted a new initiative called "Your Health Matters."that includes the reduction of barriers to employment and increasing the number of IMGs and IEHPs in practice as one of five strategies for addressing the province's health workforce needs.(NS Department of Health, 2007) The primary challenges for NS in meeting this goal are limited training capacity in health professional education programs; the relatively low numbers of IEHPs in the province--which has implications for the sustainability of various assessment and support initiatives--competition from the rapidly expanding options for assessment and bridge to employment outside the region, and the historical difficulty the Atlantic region has had attracting and retaining immigrants.

Although immigration to the region has been growing, --up from 2005 by 38% for the region and 34% for NS. In 2006— Nova Scotia's share of Canadian immigrants is only 1%. All four Atlantic provinces have problems retaining immigrants, but Nova Scotia has the second lowest rate of retention at only 40% (NS Office of Immigration, 2007).

The Nova Scotia Office of Immigration, announced an immigration strategy in 2005 with the ambitious goals of more than doubling the annual number of immigrants entering the province – an additional 3,600 over 4 years--and increasing the retention rate from 40% to 70% by 2011. It also identifies the recruitment of health professionals, particularly specialists, as a key initiative. If successful, Nova Scotia's immigration initiatives would contribute directly to the attraction and retention of IEHPs.

During the years 2005-2006 (2007 figures were not available) 111 internationally educated health professionals came to Nova Scotia more than 50% of whom were physicians. In the 7 health professions prioritized by the IEHPI and IEHP Atlantic Connection the totals are as follows: medicine-59 (family physicians-19 , specialists -40); nursing-14; medical laboratory science& medical radiation technology-4; pharmacy-8; physiotherapy-3 and occupational therapy-1.(NS Office of Immigration, 2008)

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

> **N.B**: These numbers do not, of course, reflect the number of unlicensed IMGs currently living in Nova Scotia. Fully reliable information about how many IEHPs reside in the province is not available. Although regulatory bodies can determine the number of licensed professionals whose credentials were gained outside Canada, and how many individuals have registered for re-certification, those that I have contacted do not attempt to keep track of the number of individuals who contact them for information but do not register or who are unsuccessful and drop out of the process. The Metropolitan Immigrant Settlement Association, has recently begun to keep records of IEHP clients, many of whom are not re-certified, but it is not known whether all IEHPs in the province make contact with MISA.

2 Method

This research has been undertaken as part of the Atlantic IEHP Integration Project (www.atlantichealthconnection.com) funded by Health Canada whose mandate is to identify and address gaps in the process IEHP re-accreditation and entrance to professional employment. As part of this initiative researchers from each of the four Atlantic provinces--David Bruce and Gwen Zwicker based at Mount Allison University NB, Pat Saunders Dalhousie University,NS, Scarlett Hann and Karen Dickson, Memorial University, NL, and Godfrey Baldacchino, at the University of Prince Eward Island, PEI-- collaborated in developing a standardized web-based survey questionnaire to explore whether there are shared features of the challenges that IEHPs as residents and health professionals face in the region, or its respective provinces. The project was introduced as 'work in progress' in an earlier publication, "Internationally Educated Health Professionals in Atlantic Canada", (Baldacchino, G. Chandraseke, S., Saunders, P. 2007)

Research Ethics was sought and obtained for the Nova Scotia study from the Dalhousie University Ethics Board.

2.1 Survey Development

The project was initiated by Dr.Godfrey Baldacchino, UPEI and a number of the survey questions were replicated from his earlier study of immigration to PEI to allow comparison between the two immigrant respondent groups—one group being generic, the second restricted to internationally educated health professionals. (Baldacchino,2006) Additional questions concerning key issues specific to IEHPs were developed collaboratively by the research team.

This research study employed a situational analysis, literature review and web-based survey of self-identified IEHPs. The situational analysis addressed health human resources, immigration, and current IEHP programs and initiatives at both the federal and provincial (NS) levels. The purpose of the situational analysis and literature review was to provide background for the development of the survey, and to allow for contextually nuanced and conceptually grounded analysis of the research findings.

The situational analysis included interviews held with various members of Professional Regulation Boards and educational programs, as well as document review of both federal and provincial (NS) reports concerning immigration, human health resources and IEHP initiatives and programs.

The literature review included recent research concerning retention and recruitment of health professionals in high needs areas in Nova Scotia; retention, integration and recruitment of IEHPs specifically; and the experiences and challenges faced by Canadian IEHPs as they adjust to both new social and educational/professional cultures.

Process of survey development and execution:

- Collaborative design of additional questions addressing issues specific to IEHPs by

research team

- Development of a Letter of Invitation for potential respondents and a Letter of Information for various stakeholders and interest groups The Letter of Invitation invited anonymous and confidential participation by any IEHP living in NS. The Letter of Information solicited the assistance stakeholders and interest groups in contacting known IEHPs and encouraging their participation in the study.

- Development of Consent Documents which were posted with the survey.

- Placement of the survey on a secure web-site, by Renforth Hosting, NB, on the IEHP Atlantic Connection web-site.

- Media releases promoting the study

- On-line completion of the survey between July 15, 2007 and November 9, 2007. Participants who did not wish to, or were unable to, complete the survey on-line were provided with a hard copy and invited to fax or mail a hard copy to be transferred by the researchers to the on-line survey form

- Cleaning of the data base to remove duplicate responses and ineligible participants.

2.2 Recruiting survey respondents:

N.B: Data concerning the total number of IEHPs residing in Nova Scotia is unavailable and thus the 'universe' of all potential participants was unknown. Privacy laws and research ethics required that recruitment for the study be indirect which necessitated relying on regulatory bodies(7), educational programs(4), the Metropolitan Immigrant Settlement Association (MISA), and IEHP associations(1) to contact IEHPs on our behalf by forwarding the Letter of Invitation by whatever means available Each of these was contacted again within 14 days to see if the Letter of Invitation had been circulated.

The study was replicated by the researchers in each of the other three Atlantic provinces to provide the potential for comparison of findings and regional reporting. The focus of this report are the Nova Scotia survey results.

2.3 Respondents:

The target population for this study was internationally educated health professionals residing in NS at the time the survey was conducted. We originally planned to recruit 50 respondents from each Atlantic province, however we had difficulty recruiting that many. There are a number of reasons for this difficulty including:

- Inability to identify and contact IEHPs directly and the subsequent need to use indirect recruiting methods which are not always a reliable means of accessing research

participants.

- IEHPs are a 'vulnerable research population' and tend to be 'research adverse.'

- The total population of I known EHPS in NS is relatively small and as a result the same individuals are repeatedly approached to participate in research studies. This is particularly true for those who are registered with Immigrant settlement associations and for international medical graduates who have been the target group of most IEHP research

- Health care professionals' workload prevented them from participating.

A total of **28** survey responses were received from IEHPs residing in NS of which **20** were usable (total of **93** for Atlantic Canada.) The survey questionnaire solicited response from respondents willing to participate in face-to-face interview at a future time. A contact list of **11** IEHPs from NS indicating willingness to be interviewed has been recorded.

2.4 Analysis of survey data:

- Responses to 3 sets of likert-scale questions were collated and mean scores and percentages calculated.

- Responses to 3- open-comment questions were analyzed for themes, sub-themes, inter-respondent concurrence or difference, and relationships to scaled question responses. Quotations from the written responses to the open comment questions are used in the reporting to illustrate key points and provide support for the research findings and recommendations.

2.5 Limitations:

- ***Sample size:*** As discussed above the total number of IEHPs residing in NS is not know and therefore it is not possible to estimate the statistical relevance of the data collected. In addition, the small sample size of respondents may result in discrete opinions having undue influence. The results should be interpreted as indicative and not representative of all IEHPs.

3 Survey results:

3.1 Profile of Respondent Characteristics:

The 20 respondents are almost equally divided between women(11) and men(8). Only one is over 60 years old, and only one between the ages of 50-59 years. Almost three quarters of them are concentrated in the middle of the age range (8 between 30-39 and 6 between 40-49) with three in the 20-29 year category and one of undisclosed age. All 20 claimed to speak and understand English, 5 of whom also claimed to be able to speak and understand French. Between them, the

respondents claim fluency in another 11 languages/dialects. The most common of these languages spoken were Arabic (3) and Spanish (3.)

The respondents report being born in 14 different countries with Iran(3) being the country most reported. Only 4 of the 20 were born in Europe (1 Western, 2 Southern, 1 Eastern), 7 were born in the Middle East, 5 in Asia, 3 in South America, and 1 in Africa. The predominance of IEHP respondents from non-Europe source countries, in particular from Asia and the Middle East, is consistent with trends in both national and Nova Scotian immigration as discussed above. Asked whether they considered themselves a member of a visible minority 5 of the respondents identified themselves as such:one as Southern European, one as Latino, one as Egyptian, one as Asian. Finally, one respondent, in a very interesting gesture, identified being an *"immigrant"* as belonging to a visible minority-- a salutary reminder that in a region (in)famous for its lack of curiosity and clannish distrust of , "come from aways" all new comers, visibly different or not, may experience some degree of cultural and social exclusion upon arrival. That said, we should also remember that although recent immigrants to the Atlantic region are increasingly coming from non- European countries, the percentage of the population which is comprised of members of visible minorities living in the region is still very small, even in urban areas that typically are more diverse. As a result many Atlantic Canadians have had little, if any, direct experience of ethnic and racial difference in their daily lives, a situation that can not help but compound the difficulties for immigrants from visible minorities.

Most of the respondents are very recent immigrants to Nova Scotia, all having arrived since 2000. Half (10) arrived in the period between 2006-7, 6 arrived between 2003-5, 3 arrived between 2000-2 and 1 arrived at an undisclosed date. The recency of arrival of those who choose to participate may indicate that IEHPs begin their process of integration with enthusiasm and hope and are willing to engage in positive activities such as research surveys, while later, after protracted periods of attempting unsuccessfully to gain access to professional practice, many have become disillusioned and thus much less likely to engage. In fact several IEHPs did make direct contact by phone during the recruitment period to explain that they had participated in focus groups and other studies in the past and were frustrated by what they perceived as a lack of progress in the situation of IEHPs, and to ask if I thought it was really worth their while to complete the survey.

In 18 out of 20 cases the respondent had spent most of his/her life before emigrating to Canada living in the same country as he/she was born. In at least four cases the respondents appear to have moved to other countries to study. The increased global migration of health professionals from less to more developed countries in order to access or 'upgrade' educational opportunities has been identified as one thread in the increased global migration of health professionals and reflects various 'push' factors in less developed countries including restricted access to health professional education due to discriminatory practices, lack of training capacity; and/or the poor quality of educational programs. (Dauphinee, 2008) Finally, 1 respondent reported having previously worked in Nova Scotia for a period of 12 years, before his most recent migration to Canada in 2000..

Prior to moving to Nova Scotia all the respondents had completed either a first university degree or a vocational health professional training certification program with 8 reporting the completion of further higher degrees. Several of the respondents had studied at some time outside their country of birth, while one had completed the first level of Canadian medical qualifying exams (MCCE) before coming to Canada. The movement of these respondents is consistent with the global trend of

increased migration of health professionals seeking educational opportunities out side their countries of primary residence that was discussed in the Introduction..

Four respondents report completing further degrees after arriving in Canada: 2 completed further medical training in sub-specialties (at University of Toronto and Dalhousie University), 1 completed a health administration MA degree at Dalhousie and one completed a PhD in nursing. In addition one candidate began, but did not complete, a refresher course for Licensed Practical Nurses. Two respondents reported completing the *Orientation to the Canadian Health Care System and the Health Professions for IEHPs*, one had completed, and another was currently enrolled in, the *English for Health Professionals* course offered by HILC/MISA-- both educational opportunities which have been developed as Demonstration Projects within the IEHPI Atlantic Connection.

Professional Occupation and Employment:

The respondents where asked to describe their current employment or else to declare themselves as not currently working in a health profession. 19 of 20 respondents choose to answer the question and the situations they relate attest to the individually experienced difficulties of surmounting barriers to licensure, and the *range of issues integration programs must address*.

At least ten of the respondents—50% of the total sample—were either unemployed or underemployed at the time of the study(one respondent did not report employment status and two did not provide details about the type of employment they reported.) Of those not working only two indicated that they were engaged in the process of preparing for or registered to take qualifying exams.

IEHPs all face the same types of challenges in their attempts to enter the Canadian labour market, but they begin at different stages of the process and with different levels of preparedness and resources. The nature and length of previous educational and practice experience; degree of understanding an accuracy of knowledge about the re-accreditation process in a particular profession; level of basic language skill and more advanced professional communication skills; financial resources; access to support services, and personal situation are all crucial factors that affect the length of time needed and degree of eventual success in obtaining re-accreditation and employment for any individual IEHPs. The combination of these factors will be unique to individuals and vary considerably from one IEHP to the next and we see this variation even in the small sample covered by this study. Only two Nova Scotia respondents who are unlicensed reported being actively engaged in the process of completing re-certification. Meanwhile, others had not taken the first level of qualifying exams, and their comments betray a lack of understanding of the qualifying process itself. Finally, some had taken first level exams successfully, but had not moved on to the next level of the assessment process due to either financial difficulty, lack of success at earlier levels, and/or lack of available training and skills enhancement opportunities in the province.

At *each stage*, and for *each level* of preparedness, of IEHP integration then, there is a need for *profession-specific* supports and mentoring; assessment tools and programs; bridging programs and other training opportunities as well as transition to employment and post-employment professional programs. The s*heer scope and specificity of these integration needs* makes it difficult, but necessary, to prioritize program development.

3.2 Coming to Nova Scotia

IEHPs coming to the province have spent considerable time completing professional training and certification before arriving in Canada and as a result are mature individuals who often have families. Only 4 of the respondents came to Nova Scotia alone (one respondent did not answer this question) the remaining sixteen were accompanied by a total of 33 family members (7 with a spouse/partner only, 8 with spouse and children-total of 15 children)and one with 3 others whose relationships to the respondent were not disclosed. Three of the spouse/partners were themselves IEHPs.

Three quarters (15 of 17) of the respondents came to NS of their own accord; one entered through the Provincial Nominee Program which in 2006 accounted for 33% of all Nova Scotia immigrants, another was directly recruited by a University. Three of the respondents did not disclose in what manner they had come to the province.

The survey respondents were asked to share their stories of coming to NS in an open comment question and most (16) did so. Their responses describe both 'push' factors experienced in the countries they migrated from, as well as positive 'pull' factors, some of which are general to Canada or the Atlantic region, and others specific to Nova Scotia and/or Halifax.

Those who indicated that their reasons for migrating were due more to *'push' factors* at home related the following:

> " [we] left for family reasons...wife not happy with [her] professional opportunities.*"*
>
> "I immigrated to Canada t*o* improve my quality of life as well as my financial status. I didn't select Nova Scotia for any reason other than my Uncle is present there."
>
> "Came only because of no freedom in my country."
>
> " We wish to provide economic, socio-cultural and professional opportunities for me [a female physician] and my daughter.
>
> "since after my son's post-secondary [level] there was no education in Oman—so we decided to move to Canada"
>
> " I decided to come here basically *to f*urther my educational development and see how nursing is being practiced in other parts of the world with mind of going back home in near future with experience in developing nursing in my country."
>
> " came to get work experience abroad"
>
> " I had a good position in my country ...but I like to improve my knowledge and specialty in my profession, as well the future of my daughter—her life—is important for me."
>
> for "economic reasons"

These comments confirm that limited opportunities for pursuing professional education, as well as for their children's education, act as a primary 'push' factor for some IEHPs who come to Nova Scotia, The comments also confirm what we know about the other push factors that influence the decision of IEHPs to leave their home country which include discrimination(gender, ethnic, racial) low salaries; limited career opportunities, unsatisfactory working conditions and oppressive political climates.(Dauphinee, 2008, Diallo, 2004)

'Push' factors shape initial decisions to migrate, as well as the choice of destination. Obviously if one migrates primarily in order to access educational opportunities and improve professional career options, one's choice of destination will be shaped by the educational opportunities available, but they are also likely to play an important role in decisions made later about whether to stay in a particular location. IEHPs whose educational opportunities have been limited, and/or who have trained in educational systems that are very different from Canada's, frequently require further training to meet Canadian certification standards. Access to training and bridging education becomes an absolute requisite for re-accreditation and employment and a crucial factor for IEHP attraction and retention. There has recently been a great deal of interest in *practice-ready assessment* as a possible solution for provinces with limited capacity for increasing training positions, however, these 'fast-track' programs which seek to 'take the best and leave the rest' have their own difficulties as will be discussed in the concluding section of this report.

Other respondents stressed the positive 'pull' features of Canadian and Nova Scotian quality of life and/or the attraction of secure opportunities for employment or training for themselves or their spouses; belief that the province held better job prospects than elsewhere and the presence of the Clinical Assessment for Practice Program(CAPP) a practice-ready assessment program of the College of Physicians and Surgeons NS as primary reasons behind their decisions to come:

> “My wife working as a [CAPP] physician in [....] Nova Scotia.(this respondent is a physician who plans to take the next CAPP assessment-- June 2008)
>
> “my husband came to Canada before me and my son and when we arrived we decided to stay here because it was a good city to raise my child,with perfect opportunities [for] school [for] everybody
>
> “ I wanted to live in a small town. I want to see the ocean. I had a hope that I start to work as a medical doctor very soon.”
>
> “for the space and quiet”
>
> “Recruited...asked together with my wife to open [an academic program in a health professional field.] We came with tremendous hope and enthusiasm”
>
> “my husband got a job as a Clinical Associate at QE2 hospital.”
>
> “ I had an opportunity for further training at the university and probably more options to get a job than in Ontario.”

> " The first reason behind my decision for living in Canada [it] was my childhood dream. The second reason is my kids."

One of the clear attractions of Nova Scotia for IEHPs is its wealth of medical and health professional education programs. This density of health professional educational programs also makes it likely that Nova Scotia will attract and, in the short run at least retain, larger numbers of IEHPs who are at the beginning of the re-accreditation process and/or have substantial training needs than the other Atlantic provinces—Newfoundland being the possible exception.

For other IEHPs, the presence of Halifax—the region's largest urban centre-- may be the major draw. In a pilot study exploring factors affecting retention of IMG physicians practicing in small towns and rural locations in Nova Scotia, proximity to Halifax, because of the greater opportunities for Continuing Professional Development and, secondarily, access to a greater range of cultural activities the city provided, was identified by 4 of 5 interviewees as an important factor for both quality of life and professional satisfaction**.** (Saunders, 2007a) And yet, as the following comment from one survey respondent intending to leave the Atlantic region altogether states, for those IEHPs attracted to urban locations because of their promise of a more diverse and open environment, Halifax may prove not to be 'urban' enough:

> " I would like to move to Halifax too, but I feel that Toronto is much more open to cultural diversity and there is less chance of being marginalized [t here]."

Ironically, the advantageous density of educational institutions, cultural amenities, and immigrant services Halifax provides may prove to be a somewhat mixed blessing for NS, since it may act as a pull factor for attracting the very IEHPs whose greater attachment to urban environments, or need for training opportunities that exceed the capacities of Nova Scotia's educational programs, will lead them, in the long run, to leave for larger Canadian cities.

There is a complex interaction between the factors shaping attraction and those shaping longer term retention of health professionals that needs further exploration by research tracking IEHP retention over time, as well as by qualitative studies that focus in more depth on individual IEHPs' and IEHP sub-groups' experiences and perspectives. Meanwhile we might expect proximity to the city to have retention potential for those IEHPs who have come for the quality of life and types of professional practice afforded by s*maller communities*, but still place *some value* on accessing urban amenities with relative ease. This type of life style, which seeks to combine the 'best of both worlds,' is very possible in NS, where the combination of low population density in the areas surrounding Halifax, and a reasonably good transportation infra-structure, support ease of access to Halifax from surrounding communities.

The survey also asked respondents to rank the importance of a series of ten statements in shaping their decision to come to Nova Scotia. The scoring was done using a likert-scale of 1-5: 1 indicating the least and 5 the greatest significance. The higher the mean score for a statement the more significant that statement can be considered as a reason for the decision to come to Atlantic Canada.

Respondents reported having *attractive job prospects in Atlantic Canada*; the *attractive quality of life* offered; and its provision of an *overall welcoming society*, as the principal reasons behind their

decisions to come to NS. (see table Table 1 below) Quality of life and welcoming community are fairly straightforward factors to understand. It would be useful, however, to know more about how IEHPs *evaluate job prospects* as distinct from secure offers of employment in the region/province. Do they hear stories-- and if so, from where -media? Web-sites? Recruiters? IEHPs already in Canada or the province?--about shortages of health professionals in the region and make the logical assumption that the shortage will improve the chance of finding professional employment upon arrival? Another explanation is that they assume that larger centres and more densely populated areas may have more jobs, but also more competition. What ever the case, as Dr. Tabinda Sheikh, Vice-President of the Association of International and Physicians NS (AIPS-NS , 2006) reminds us, many IMGS come to the province with high hopes that are not realistic under present conditions. A better sense of *how IEHPs gain their knowledge about re-accreditation and employment opportunities* in the province/region would be helpful in effectively meeting recommendations made by several IEHPs respondents in the final open comment section of the survey and by AIPS-NS, that up to date and accurate information about licensure, training, and employment be made more available *at the time of immigration.*

In addition, ensuring that IEHPs understand in advance of arrival that employment opportunities in the region are quite likely to be in small towns or rural locations, and also that they are well informed about the nature of professional practice in these locations, appears to be particularly important for later retention. Research conducted with Australian IMG physicians on factors affecting retention in high need areas indicates significantly higher retention rates for those IMGs who had greater prior knowledge of the conditions of professional practice they would encounter in these locations. (Han, G. Humphreys, J. 2006))

Table 1: Importance of statement in determining decision to come to Atlantic Canada: Mean Scores and Percentages of scores of 4&5[2]

How important have the following been to YOU in determining your decision to COME to Atlantic Canada ?	N/A	1	2	3	4	5	Mean Score N=20	Percentage N=20
a. There was an attractive job available in Atlantic Canada	5	7	0	3	3	2	2.53	33
b. There were attractive job prospects in Atlantic Canada	5	4	1	3	4	3	3.06	47
c. We had relatives and friends already in Atlantic Canada	4	9	0	0	2	5	2.63	44
d. We had members of the same church/religion in Atlantic Canada	6	13	0	0	1	0	1.21	7
e. Atlantic Canada offered suitable and affordable health services	5	8	1	4	1	1	2.38	13
f. Atlantic Canada offered suitable and affordable schooling	4	8	2	3	0	3	2.25	19
g. Atlantic Canada offered suitable and affordable programs for ongoing professional development	6	4	3	4	1	2	2.57	21
h. Atlantic Canada offered suitable and affordable housing	5	7	2	2	3	1	2.20	27
i. Atlantic Canada was an overall welcoming society	5	4	1	3	3	4	3.13	47
j. Atlantic Canada offered an attractive quality of life	4	4	3	2	4	3	3.06	44

2 Percentagesr efer to the combined scores of 4 and 5 (greater significance) given to a statement represented as a percentage of the statement's total scores.

Almost half of the Nova Scotia respondents accorded a major or crucial importance to statements b. *attractive job prospects* (47%), c. *having friends and relatives in the region*(44%), i.. *an overall welcoming society (47%)* and j. *attractive quality of life (44%)* (see Table 2 below).

The presence of friends and relatives is the only factor to *gain significance*, when the respondents' rankings are calculated by percentage of 4 /5 responses rather than by mean scores, but is worth noting that while 7 respondents reported this factor as major or crucial, the other 9 respondents all gave it the lowest possible score of 1 -- no relevance. While the small number of respondents makes it difficult to know how representative this split response might be, what it does at least suggest is that the respondents who consider friends and family a factor at all, also consider them to be a very important one and therefore it may have positive implications for retention of this sub-group. (see Baldacchino, 2006 for a discussion of the bonding role of friends and family for immigrants' sense of place) In direct contrast, just over half the respondents accord it the least importance in determining there decision to come, underscoring the fact that for many IEHPs opportunities for professional integration will take precedence over other factors when choosing where to reside. The combined effect of a pragmatic attitude and the absence of personal ties to the region means many IHEPs remain mobile and more likely to leave if their chances for attaining professional re-accreditation or full integration appear to be better elsewhere. The absence of a social network of family and/or friends may also lead to greater cultural isolation and longer term marginalization for both the IEHP and his/her family having implications for retention. In Nova Scotia the District Heath Authority have taken the initiative to publicly introduce a CAPP physician new to Yarmouth through a news release and an open house event. This form of 'welcoming' community activity might mitigate initial feelings of being a 'stranger in a strange land.'

3.3 To Stay, or Not to Stay, in Nova Scotia:

Staying in Nova Scotia:

When posed a simple question about whether they intended to leave NS or the Atlantic region most of the respondents (14 of 17 responses) reported their intentions to stay in NS. For the most part the the reasons that were given when asked to elaborate on reasons for staying in the region and/or province are similar for the those given for coming placing the highest priority on *quality of life, rewarding employment, and welcoming communities :*

> “like the people here..are very kindly...”
> “the people here are friendly and accommodating”
> “kids like it here and we are too old for the German labour market.
> “Because I like the city”
> ”My wife got in the system in NS, I may also get into system in NS, we like community, people are friendly and we would like to be loyal to province which gave us the necessary break'
> “[staying] for good quality of life in this province, high level [of]universities and schools, high level [of] culture”
> “my husband and I got stable and rewarding jobs and liked the lifestyle and people
> “have jobs, house, family”

For one respondent family ties and support were the main reason for remaining:

> "Besides the presence of my uncle is the strongest thing that let me continue my life here"

Reasons for staying need not always be positive however, as 2 respondents who noted that they no longer had the financial resources needed to make a choice possible remind us.

> "have no other way. No money"

Those who indicated their intentions to stay in NS were also asked to rank how important each of a series of 14 statements had been in determining their decisions, using a likert -scale of 1 to 5, with 5 indicating the highest and 1 the lowest significance. Some of the statements included in this question were the same as those given in the series of statements used to rank reasons for coming to the region and/or province in order to discover whether there were differences between the initial reasons for coming and those underlying later decisions about whether to stay.

As in the written elaborations sampled above, *quality of life* and *employment prospects* are identified as the most significant reasons for staying. The *safety of the region for raising a young family* received the highest mean score (4.30,) with the third and fourth highest scores given to the *welcoming quality of neighbourhoods* (3.50,) and the *attractive lifestyle* the region provides(3.25.).And although the written elaborations of reasons for staying more often mentioned having *actual jobs*, the respondents report that *having job prospects* (3.54.) was the second most significant reason for remaining in the province. Given that all of the survey respondents are recent arrivals and that a number of them reported being in the process of re-accreditation, or having just completed qualifying exams but not yet working, this is not surprising. Whether, and for how long, job prospects alone would remain a strong reason for staying in the province remain an unanswered question in need of further study.

A comparison of the principal reasons for coming and those for staying reveals them to be virtually the same, with the only slight adjustment being that the *safety of the region for raising young families(* not included in the reasons for coming) takes 1st place in reasons for staying, while *having attractive job prospects* which ranked as the 1st reason for coming to Nova Scotia, becomes the 2nd reason for staying. This slight change in ranking that places having job prospects second to the safety of the region for young families probably results from the shifting priorities of those respondents who found jobs after arrival.

Table 2: Importance of statement in determining decision to stay in NS or Atlantic Canada: Mean scores and Percentages of scores of 4&5[3]

How important have the following been to you in determining your decision to stay (so far) in Atlantic Canada?	N/A	1	2	3	4	5	Mean Score (N=20)	Percentage (n=20)
a. I have an attractive job available in Atlantic Canada	9	5	0	2	3	1	2.54	36
b. I have attractive job prospects in Atlantic Canada	9	0	1	3	2	4	3.54	54
c. I have close relatives and friends already in Atlantic Canada	8	6	2	1	0	3	2.33	25
d. I have members of the same church/religion in Atlantic Canada	10	6	2	1	1	0	1.30	10
e. Atlantic Canada offers suitable and affordable health services	8	5	3	2	1	1	2.16	17
f. Atlantic Canada offers suitable and affordable educational services	8	3	4	2	1	2	2.58	25
g..Atlantic Canada offers suitable and affordable professional development and training experience	8	5	2	1	2	2	2.50	33
h..Atlantic Canada offers suitable orientation programs to non-Canadian medical and/or paramedical staff	8	4	3	1	1	3	2.66	33
i. Atlantic Canada offers suitable and affordable housing.	9	3	1	4	3	0	2.63	27
j. Atlantic Canada offers suitable settlement services	9	4	2	1	4	0	2.45	36
k. Atlantic Canada offers offers an attractive way of life	8	2	0	4	5	1	3.25	50
l. We feel welcome in our neighbourhood	8	0	3	2	5	2	3.50	58
m. Atlantic Canada is a safe region where to grow a young family	8	0	0	3	2	7	4.30	75
n. Atlantic Canada offers suitable language training	8	2	3	3	2	2	2.90	33

Not Staying

Those who indicated they intended to leave the province and region (18%) were invited to elaborate on the reasons why. Like those who intend to stay, the quality of experience within communities and difficulty entering professional employment are the of primary importance. Those leaving related negative experiences of community citing concerns about marginalization, cultural insensitivity to difference and unequal treatment, and the frustration over not finding pathways to professional employment reason for leaving. One respondent, a surgical specialist, explained that the only employment option he found in NS had been a “day care position.” While another, who has been working as a health professional in NS for 7 years, describes his (and his health professional spouse's,) experience of cultural and workplace exclusion in direct and pointed terms:

3Percentages refer tothe combined scores of 4 and 5 (greater significance) represented as a percentage of the statement's total scores..

> "I have experienced some underhanded racist behavior in my life before BUT never of the magnitude and consistency as that experienced in [---], NS. We have ...been shunned, insulted, told to go back where we came from, denied resources that everyone else has been given... I suspect that is enough."

It may be tempting to discount the experiences of the respondents who recount experiences of marginalization and racism as atypical, particularly as the survey respondents include the region's overall welcoming quality as one the primary reasons in deciding to come and to stay in Nova Scotia. However, and albeit in more neutral and non-specific ways, concerns about the "lack of cultural diversity" also appear in the comments of some of those intending to stay. It is possible that, in part, references to cultural *diversity* serve as a euphemism for what is experienced as a lack cultural *tolerance*. It is also possible that IEHPS who have experienced social marginalization or overt racial discrimination are much less likely to have stayed than those whose experiences have been positive.

3.4 Attracting other IEHPs to Atlantic Canada/Nova Scotia:

In the final section of the survey respondents were asked to rank, on a likert-scale of 1-5, a series of 17 statements according to their judgment of what the important obstacles or problems for attracting other IEHPs to the region/province are. The higher a statement's mean score, the more significant the obstacle/problem is considered to be a factor in the attraction of IEHP immigrants to the region/province.

Their collective response points to a combination of geographic location, socio-economic conditions in the region, and barriers to health professional integration. Specifically, the factors affecting attraction of IEHPs receiving a score of 3.21 or more were as follows: ease and cost of travel in and out of the region (3.780) ; lower salaries and wages relative to the rest of Canada (3.57); lack of meaningful and challenging employment opportunities for health professionals(3.53); lack of meaningful and challenging training opportunities for health professionals (3.25) and finally, limited choice and greater expense of goods and services in Atlantic Canada (3.21.)

When the scores are calculated by percentages of respondents who give a score of 4 or 5 to a statement, *lack of health professional employment* (54%) ranks second, after *ease and cost of travel in and out of the region*(71), while *training and educational opportunities for health professionals*(50%), and *lower salaries/wages in the region* (50%) share the third position.

Salary levels and cost of living are issues that become acutely important for IEHPs (and presumably other professional immigrant) whose employment prospects are still dependent on access to training /education opportunities and achieving re-certification. As the earlier findings for reasons for coming to the region indicated, many IEHPs arrive in the province/region without secure employment, their hopes pinned to the *prospect* of jobs. The next stage for many involves the arduous effort to make a living, often at wages barely above minimums and in employment unrelated to their professions, while still finding time to prepare first for qualifying exams, and then for further assessments. It should not be surprising that, under these often prolonged conditions of financial pressure and constraint, IEHPs are sensitive to the region's lower salaries/wages and higher costs of living as main obstacles to attracting others to the region.

Table 3: Obstacles and problems for attracting IEHPs: mean scores and percentages of scores of 4&5[4]

How serious would you consider the following to be as obstacles and problems towards attracting other internationally educated health professionals to Atlantic Canada?	N/A	1	2	3	4	5	Mean Score (n=20)	Percentages (n=20)
a. Atlantic Canada is small, isolated and remote	6	4	0	6	2	2	2.85	29
b. There is a lack of cultural diversity in Atlantic Canada	7	5	1	4	0	3	2.92	23
c. Atlantic Canada does not offer satisfactory settlement assistance	7	3	4	4	1	1	2.46	15
d. Atlantic Canada does not offer satisfactory language service assistance	6	7	3	3	1	0	1.85	7
e. Goods and services are limited in choice and yet more expensive in Atlantic Canada.	6	2	3	3	2	4	3.21	43
f. The quality of education in Atlantic Canada is not up to standard	7	5	2	2	2	2	2.53	31
g. The quality of health care in Atlantic Canada is not up to standard	6	7	4	1	1	1	1.92	14
h. Atlantic Canada has insufficient health professionals	8	4	2	2	2	2	2.66	33
i. Meaningful and challenging employment opportunities for health professionals in Atlantic Canada are lacking.	7	2	1	3	2	5	3.53	54
j. Meaningful and challenging training opportunities for health professionals in Atlantic Canada are lacking.	8	3	1	2	2	4	3.25	50
k. The weather in Atlantic Canada is too harsh.	6	2	2	6	2	2	3.00	29
l. Atlantic Canada does not offer suitable orientation programs to non-Canadian professionals.	7	5	4	1	0	3	2.38	23
m. Newcomers do not really feel welcome in Atlantic Canada	6	7	4	1	1	1	1.92	14
n. There are too few people from other countries in Atlantic Canada	6	3	5	2	2	2	2.64	29
o. There is a lack of ethnic food and restaurants in Atlantic Canada	6	3	5	1	1	4	2.85	36
p. Salaries and wages are lower in Atlantic Canada than in the rest of Canada	6	0	3	4	3	4	3.57	50
q. Flights to/from the region are few, expensive &inconvenient	6	1	2	1	5	5	3.7	71

3.5 Identifying main obstacle(s) for attracting other IEHPs to the Region:

Respondents were asked to further indicate--again based on their individual perceptions of the challenges involved in relocation to NS and the integration process-- what they would consider to be the *main* obstacle(s) for attracting other IEHPs to the Atlantic region.

Thirteen respondents chose to provide further insights regarding the main challenges faced by IEHPS in the province/region often identifying more than one obstacle. Barriers to meaningful health professional employment remain the most frequently cited concern, with lack of training opportunities, difficulties obtaining a license to practice, and a lack of support during the process of obtaining re-certification are also repeatedly noted. As one respondent succinctly describes the situation:

4 Percentages refer to the combined scores of 4 and 5 (greater significance) represented as a percentage of the statement's total sores.

> Obtaining a license to practice anywhere in Canada, even in the Maritimes, is very difficult, especially for international medical graduates. The process is lengthy and uncertain. It is certainly a financial challenge as well."

Lack of cultural diversity (which received a mean score of 2.92 in the ranked question concerning obstacles to attraction of IEHPs) and lack of social and cultural activities were also mentioned as main obstacles, as was the feeling that previous professional experience of IEHPs was discounted and undervalued by Canadians:

> " the main problem is the examination system. I am a specialist. Why do I need to pass medical school board exam(MCCE1). I finished medical school twenty years ago."

> "It is a shame that experience doesn't count [for] anything here. We [have] worked for twenty years and have to take an exam like a new student'..

Finally, insufficient promotion of the opportunities for IEHPs in the Atlantic region, and the magnetic draw of Toronto for IEHPs due to the presence of social networks, and what the one respondent described as a widespread, though erroneous, perception that Toronto provides better job prospects were cited as further problems for attracting other IEHPs.

4. Concluding Discussion and Policy Implications

> *"The colleagues of a Muslim doctor indicate that she is being harassed by her husband. A Chinese doctor feels discriminated against because of his strong accent and is contemplating returning to the factory where he worked unpaid hours but was left alone. The father of another is dying; she can spend her money either flying overseas to see him or saving up for her exam. Beneath their affable smiles lies a private world of doubt, resignation, and impossible choices. They wear their medical degrees like ill-fitting coats—too awkward to parade but too warm to discard. I console myself that perhaps if I just help them get through the exam, the other pieces will fall into place."*
>
> Ranjana Srivastava, F.R.A.C.P. IMG tutor " A Bridge to Nowhere"

The stories and voices of the Nova Scotian IEHPs who responded to our survey, all but one of whom arrived after 2000, directly confirm much of what we know about the increased barriers to integration and professional employment experienced by recent Canadian immigrants. Confusion about the requirements for re-certification; the need for support at each stage of the process; the difficulty in accessing assessment and educational/ programs; difficulty gaining Canadian work experience in professional fields; frustration over the length of time, financial burdens, and general uncertainty the whole process entails; the struggle to gain full language fluency and understanding of Canadian health education systems and professional cultures all appear in the challenges as described by the respondents, and have been documented elsewhere.(Fiscella, 1997, Hall, Heeley, Dojeije, Byszewski &Marks, 2004, Rao, 2007, Whelan, 2006, Nyapati, 2007) **We** are also beginning to discover which measures and strategies have been effective in reducing many of these barriers. Among the most

frequently identified are: early contact to provide information and career/employment counseling, language support adapted to the workplace, financial assistance programs tailored to the needs of IEHPs, and mentoring programs that bring IEHPs and established professionals together. (Audey and Gagnon 2007, Wong and Lohfeld, 2008.) Through the IEHP Atlantic Connection and its institutional and health professional partners a number of projects are underway that seek to implement support programs to aid IEHP integration.

Because the stage in the re-accreditation IEHPs have reached before coming to the province varies considerably, the range of integration services needed is broad. Although there is some overlap in IEHPs needs such as career and employment counseling, orientation to the Canadian health care system and language courses for health professionals, the supports needed for preparing for qualifying examinations and assessments are necessarily profession-specific, as are the needs for assessment programs, bridging programs and training opportunities**. Finite resources make it necessary to prioritize which levels of program development, and which health professions, will receive resources.**

Better information about the numbers, and level of progress toward licensure, of IEHPs now residing in the province and region is needed.

We know a good deal less about what attracts IEHPs to particular provinces, or about what retention strategies will successfully induce them to stay. I noted earlier that the data reported here suggests that Nova Scotia's wealth of educational opportunities may act as a draw, particularly for those IEHPs whose decision to migrate was motivated by a desire to further develop their professional skills. While this a strength for Nova Scotia, it can only be realized if greater training and education capacity is found. The NS Office of Immigration has recently begun an initiative to recruit international students as potential immigrants. **The Department of Health could benefit from the Post-Secondary International Student Immigration initiative by working directly with the Office of Immigration and educational institutions. Greater co-ordination between the Department and Office of Immigration would also ensure that the Office of Immigration recruitment of IEHPs is co-ordinated with the assessment or further skills enhancement programs available**.

Precisely because of limited training positions the College of Physicians and Surgeons NS began **a** clinical assessment for practice-ready physicians to address the acute need for Family Practitioners in rural communities. Successful CAPP candidates enter practice in a 13 month mentorship program that includes paid mentor, monthly self-assessment and mentor reports on progress, a 10 month external assessment, and a 360 degree assessment at the end of the mentorship period. The CAPP assessment is limited to assessment for family practice. Nova Scotia does not, as yet, have a program for assessing IMG specialists. It is worth looking at this program for the light it can shed on the recruitment and retention of IEHPs in the province/ region and in order to consider the strengths and limits of practice-ready programs as a solution to limited training and bridging capacity.

If we build it will they come?: The Case of the Clinician for Practice Program

Nova Scotia is still the only practice-ready physician assessment in the Atlantic region and at its inception in 2005 it was the *only practice-ready program in the country*. Not surprisingly the first two assessments drew many candidates from out of province, some of whom brought spouses who were physicians as well. As of June 2007--27 CAPP Family Physicians are practicing in Nova Scotian

communities; 2 in the Capital Health District and 25 in rural and small town locations throughout the province. What CAPP has demonstrated is that innovative, high quality assessment programs that promise direct access to employment *will, at least initially, attract health professionals into the province*, and have *an immediate impact* on health professional shortages. So the answer to the question if we build will it, they come appears to be a resounding yes. Whether they continue to coma is a different question. As other provinces (Ontario, Manitoba, and a coalition of western provinces)) quickly followed suit with their own practice-ready programs, the number of candidates registering to take the CAPP dropped significantly. The financial viability of CAPP requires achieving a minimum of 20 registered IMG candidates for each annual assessment. It remains to be seen whether this will be possible over time. The long term sustainability of IEHP programs will affect the success of recruitment, retention and integration alike. **In light of competition with other regions, and of the rapidly developing movement toward national standardization of assessment and licensing procedures to increase IEHP mobility within the country, the Atlantic provinces must collectively commit to a regional strategy. No one province has the numbers of IEHP clients, nor the program capacity to absorb the numbers that would be needed, to mount and sustain IEHP integration programs across all seven targeted professions.**

The story of CAPP to date is an important one for NS and the rest of the region, as it underscores the difficulty of *sustaining* the ongoing and substantial costs of IEHP clinical assessment and various other types of programs and services in a region where the real numbers of potential IEHP clients are relatively small. The fact that provinces outside the region are aggressively competing for IEHPs, and often doing so with access to larger budgets and greater numbers of IEHPs compounds the problem and makes regionally-based strategies and cooperation imperative. (Bueckert, 2005)) The program also raises a further issue concerning practice-ready assessments. The success rate for CAPP is approximately 30% --not unreasonable for this type of program-- but the cost of the assessment for each IMG is $5,000.00 and for those who are unsuccessful meeting the practice-ready standard there is no further step in place. All candidates do however receive very detailed assessment reports that could be used for placement into training programs. **Capacity to offer further skill enhancements should be developed, at least for those who come close to meeting the practice-ready standard, in order to fully utilize the assessment resources of CAPP.**

Support for on-going research and evaluation of 'practice-ready' fast-track assessment models for IEHPs should be a priority.

Practice-ready assessment does uniquely meet a number of objectives: it provides early intervention in the IEHP re-accreditation process, reduction of the psychological experience of lost professional identity and of uncertainty, immediate financial stability and, through formalized mentoring, supported integration to the *professional culture whose* contextual features and expectations are largely tacit and therefore inaccessible to IEHPS, all of which have been shown to be important to successful integration.(Srivastava, 2008, Wong and Lohfele, 2008, ,Rao,2006, Bernstein, 2000) They also attract IEHPs with strong skills who have not been out of practice for long. The trade offs are that they have fairly high ongoing costs, hat only a small percentage of IEHPs meet the eligibility criteria and from within that group not all will be practice-ready. IEHPs who are not practice-ready see these types of programs as a start, but the 'take the best leave rest' appears callous and does little to utilize IEHPs already residing in the province but who do not meet the eligibility criteria. (AIPSO, 2006) **A recommendation has been made by MISA and AIPSO that resources be directed to IEHPs who have already settled into the province and thereby demonstrated a commitment to staying,. This**

recommendation should be reviewed and assessed. While it is true that such a policy might improve retention, factors such as how long the IEHPs in question have been out of practice, whether they have completed qualifying exams, or have been working in health care related fields should be taken into account as these factors will affect the levels of integration support required and the success rate of the group targeted.

Strategies for the retention of IEHPs have received much less attention than efforts to reduce the barriers to employment, for the obvious reason that without these efforts there will be few IEHPs to retain! IEHPs are often discussed as though they were a homogeneous group, but differences in profession, gender, age, amount and type of previous education and practice experience, to name only the most obvious, all form particular sub-categories with the group as a whole. While there has been little research that attempts to look more closely at these differences, a recent study of retention of IMGs in rural Australia forms a notable exception and has direct relevance to this report. Based on interviews with 57 IMGs on return for service contracts in rural locations the researchers identified four types of IMGs categorized by their degree of integration into rural communities. They are 'satellite operators'(city-oriented), 'fence-sitters' (affiliated with city fringe areas), the 'ambivalent' (unsure about their future settlement place), and those 'integrated' into rural communities. (Han, G. Humphries, J. 2006).Those most integrated into rural locations, were the most aware of the requirement that they begin practice in a rural location at the time of immigration, did not regard relatives as a key influence in determining where to live, were able to live comfortably as a minority in a foreign culture—accommodating occasional discriminatory comments or acts--, were pragmatic about the limits of rural life, and valued they what perceive to be the collegial and co-operative work environments in rural communities. At the other end of the spectrum 'satellite operators' were likely to attempt to live in the city and commute to their rural practice. They rarely remain past their mandatory period, returning to the city which is the centre of their family's cultural needs. “Fence sitters' live within 60-100 kilometers of the city and experience living between cultures –rural and urban—as having the best of two worlds, a life style I earlier suggested was a possible attraction and retention feature NS is well placed to promote. Finally those who are ambivalent remain unsure of whether they will remain, but can sometimes be persuaded. Often educational opportunities for children or spousal employment are the source of uncertainty rather than a desire to be in an urban environment. For the sake of brevity, I have simplified the typology the researchers present, but even in reduced form it usefully points to the heterogeneity of IEHPs and the unlikely success of 'one size fits all policies' for addressing retention – or recruitment—challenges.

The Department of Health should support further IEHP recruitment and retention research, and develop proactive strategies and initiatives for retaining IEHP physicians that target those most likely to stay.

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