

# Opposing Practice Location Restrictions for Graduating Canadian Medical Students

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*Position Paper*



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Date: September 20<sup>th</sup>, 2019

POSITION PAPER

## Summary

One strategy imposed by provincial governments to address the longstanding issue of underserved rural communities involves the utilization of Return of Service (ROS) contracts. In recent years, ROS contracts have surfaced that require newly graduated Canadian medical students (CMGs) to relocate to an underserved area immediately upon graduation for a set number of years and impose strict penalties if the conditions of the contract are not met. This paper explores the issues surrounding the use of this specific type of ROS contract and posits that is a poor strategy in tackling the challenges of underserved areas. This paper also seeks to discuss the implications of placing these contracts on newly graduated CMGs, and the financial and social repercussions inherent therein. We believe that these contracts are detrimental to Canadian medical students while also failing to address the challenges faced by underserved communities. In lieu of practice-location restrictions, we call on governments and postgraduate medical faculties to address the root causes of rural/urban health disparity and to increase efforts to train students from rural communities. These models have been proven to work, and do not rely on the forced relocation of urban students to rural areas, an ultimately harmful and ineffective practice.

## Introduction/Background

Throughout Canada, there has long existed an uneven distribution of physicians serving its communities. Rural areas in Canada constitute 18% of the Canadian population, but are served by only 8% of the physicians practicing in Canada.<sup>1,2</sup> Due to various geographic, environmental and systemic factors, Canadians living in rural areas continue to face numerous barriers in accessing healthcare. In fact, in 2014, the College of Family Physicians of Canada (CFPC) and the Society of Rural Physicians of Canada (SRPC) formed a joint task force solely with the goal to improve the health of rural Canadians.<sup>3</sup>

Among the strategies used by governments to increase physician services in rural communities are Return of Service (ROS) contracts. An ROS contract is an agreement typically undertaken by a medical trainee or a physician new to practice in Canada, which imposes an obligation to work in an underserved area for a set number of years in exchange for a specific residency position, monetary compensation, or loan forgiveness. Specific ROS obligations vary from province to province and eligibility criteria differ based on level of training. Although traditionally meant for International Medical Graduates (IMGs) looking to relocate to Canada and obtain full medical licensure, ROS contracts have also found their way into agreements with newly-graduated Canadian Medical Graduates (CMGs). In 2018, as a response to advocacy efforts by medical students to increase residency spots, the Ministry of Health and Long-Term Care in Ontario created 53 new one-time residency positions; however, all of them were tied to an ROS contract.<sup>4</sup> Recently, select second iteration spots in CaRMS across Canada added an ROS contract tied to their programs.<sup>5</sup> Subsequently, in the 2018-2019 CaRMS cycle, a first iteration dermatology residency spot in British Columbia was tied to an ROS contract.<sup>6</sup> Now, in the upcoming 2019-2020 CaRMS cycle, additional ROS spots have been tied to multiple first iteration CMG spots, including anesthesiology, emergency medicine, and dermatology from Dalhousie University, and family medicine from Northern Ontario School of Medicine.<sup>5</sup>

Unfortunately, data has shown that contracts which impose a restriction on where physicians can work are ineffective long-term strategies that fail to address underlying issues of poor retention in underserved areas. IMGs who accept ROS contracts have an incredibly high turnover rate.<sup>7,8</sup> It has been shown that IMGs will often agree to complete their training in certain underserved areas of Canada as “entry-points” to obtain full licensure in Canada, and leave once their contract is over.<sup>7,8</sup> Additionally, it has been demonstrated that postgraduate training location is a significant predictor of future work location among CMGs, particularly in rural areas. A study of physicians who graduated from Memorial University of Newfoundland between 1973 and 1998 showed that over 95% of those who remained working in Newfoundland and Labrador by 2004 were actually originally from Newfoundland and Labrador.<sup>20</sup> Furthermore, although it was demonstrated in a similar study that medical trainees who take their ROS agreements in Newfoundland and Labrador do complete their service commitments in full, it was revealed that most physicians who made this choice wanted to work in these underserved communities in the first place.<sup>21</sup>

Creating residency spots based in urban areas targeted at CMGs with an urban background will expectantly result in CMGs returning to urban areas to practice, after a temporary forced relocation to an underserved area. A temporary relocation of these physicians to rural areas

essentially creates a “revolving-door” of physicians in underserved areas with perpetually reduced continuity of care. This is detrimental to patient care, as continuity of care has been well-documented in the literature to be beneficial and associated with lower morbidity and mortality rates.<sup>10,11</sup> Moreover, practicing in rural and underserved areas is a privilege, although implementation of this privilege as a contractual requirement does not convey it as so. The reality is that rural medicine is incredibly challenging and rewarding work that many physicians enjoy; it simply is not suited for everyone.

For historical context, the issue of provincial governments instituting controversial policies to improve healthcare presence in rural communities is not new. In 1997, a lawsuit was filed against the Medical Services Commission of British Columbia by the Professional Association of Residents in BC (PAR-BC, now known as Resident Doctors of BC) for the creation of “restricted billing numbers”. Similar to ROS contracts, this was an attempt to relieve medically underserved areas. Under this model, new physicians who received a billing number after 1994 would receive a “restricted billing number.” This meant they could only receive 50% of their billing amounts if they were servicing an “over-serviced”/urban area but would receive 100% of their billings if servicing an “underserved”/rural area. This lawsuit eventually escalated to the Supreme Court of British Columbia where it was found to be in violation of the Canadian Charter of Rights and Freedoms - specifically Section 6, Mobility Rights.<sup>12</sup> As a result, the new measures introduced by the Medical Services Commission were ultimately struck down.<sup>13,14</sup> The ROS contracts currently offered in the first iteration of the CaRMS match similarly restrict the portability of the medical profession and physicians’ right to move within Canada, and thus can potentially be subject to similar legal challenges.

Most importantly, it is unreasonable for provincial governments to attempt to place the burden of healthcare delivery and distribution onto newly graduated medical students. Because medical students are facing increased pressures at matching to a residency, some students may hastily apply for an ROS residency position out of fear of going unmatched - although this can, in part, be mitigated with proper career counselling from schools recommending students to not rank placements they do not want to match to. However, with fear acting as a motivator to accept an ROS contract and no true desire to work in a rural area following full licensure, the ROS model has the potential to exacerbate the “revolving-door” in rural healthcare delivery and further contribute to the stigma of rural medicine as an undesirable medical practice option. Unequal healthcare distribution is an age-old issue in Canada, and it requires tangible government action at many levels to resolve the issue. Solely targeting newly trained physicians to work an ROS contract provides a temporary solution with minimal long-term viability.

Due to the cost of medical education, the amount of student debt accrued by medical students is consistently very high. For most students, provincial student loans and personal savings are not able to cover all costs, so students seek out lines of credits from banks. This debt is another primary driver of why medical students are seeking to match to residencies, as receiving payment in residency will help to begin paying down their medical student debt. However, under the ROS contract terms from first iteration spots in the CaRMS match for CMGs, if a trainee breaks their ROS contract, they would have a contractual obligation to pay an exorbitant fee. As an example, for the dermatology ROS contract introduced in the 2018-

2019 year in the 1st iteration of CaRMS, the “repayment on termination” amount was \$979,581 - nearly 1 million dollars.<sup>7</sup> This is an undeniably unreasonable fee to pay for any working professional, much less a medical trainee with a large amount of debt. Additionally, it is not uncommon for trainees to change their field of practice and switch residencies. This is permitted by postgraduate faculties because they recognize it is highly undesirable to force a trainee to complete a residency that they do not want. However, these ROS contracts contain no such provision and thus any attempt to switch residency, or any inability to complete the residency besides grievous injury or death, results in the full bill owing. We believe this is an unacceptable burden to place on trainees, as has the potential to negatively impact the health and wellness of learners as these contracts become more ubiquitous, as is already occurring.

It is worthwhile noting, however, that service agreement programs vary between provinces and programs and certain agreements have been shown to help with retention of physicians. A 2013 study on Newfoundland’s “Return-for-Service (RFS)” program demonstrated that when these RFS agreements were offered as optional, bursary-type incentives (rather than a contractual obligation with a financial penalty if not agreed to), retention rates for physicians to stay in Newfoundland were much higher. In general, RFS agreements linked to bursary were more effective than RFS agreements linked to residency position funding.<sup>22</sup>

Please note that as this position paper is presented to the CFMS (Canadian Federation of Medical Students), it is meant to advocate specifically for Canadian medical students, as we are only able to speak to the unique experience of Canadian medical students. This paper is thus speaking against these contractual obligations for CMGs.

## **Principles/Stance**

The CFMS endorses the following principles in support of a stance discouraging the use of contracts that contain practice location restrictions targeted at newly graduated CMGs.

1. Restricting practice locations for newly graduated CMGs is not an appropriate or sustainable solution to the current issue of rural and underserved areas. This model creates a lack of proper long-term care for patients in rural areas, communicates an inaccurate negative message about rural medicine, and places an inappropriate burden on Canadian medical students, inappropriately limiting their freedom of movement and negatively impacting their financial and emotional wellbeing.
2. Increased, action-oriented effort should be placed on finding alternative solutions to serving the healthcare needs of rural and remote areas.
3. Collaboration between the CFMS and medical student societies should ensure that discouraging the use of location-restricting contracts for CMGs remains an important advocacy piece in the context of advocating for more residency spots from our provincial governments.

## **Concerns**

**Concern 1:** ROS contracts are ineffective in achieving a sustainable solution for underserved areas, yet are increasingly being tied to residency positions for CMGs.

Location limiting contracts need to be discouraged as there is no data to support that they are effective for long-term healthcare delivery in rural areas. As these contracts have slowly been introduced for CMGs - now in multiple different programs and different schools during the first iteration of the CaRMS match - there is significant concern that this will continue to spread to other programs in other provinces. As more and more contracts become established, it will normalize the practice of restricting mobility of newly graduated CMGs and could potentially create a system where Canadian-trained physicians cannot expect any control over their location of practice once graduating residency. This is a clear violation of physicians' freedoms and efforts must be made to prevent these contracts from increasing and spreading to other programs across Canada.

The CFMS understands that recruitment in underserved areas is an issue, but this approach is a very targeted, unsustainable solution that is taking advantage of newly-graduated medical students who are vying to match in an increasingly competitive process. We do wish to note that although the contracts being discussed are labelled as "ROS contracts", we do not wish to place all ROS contracts as a whole under a spotlight. Rather, the issue lies with this specific type of ROS contract: imposed on residency positions reserved for newly graduated CMGs who are entering the CaRMS match, with unreasonable contractual obligations and penalties attached. It is this specific training model that the CFMS is advocating against. Although a discussion on ROS contracts as a whole is indeed relevant to this conversation, it is beyond the scope of this paper, since a great diversity of ROS contracts exist in Canada, each with their own specific restrictions and limitations, benefits, and challenges, which cannot all be generalized together.

**Concern 2:** ROS positions targeted at newly graduated CMGs entering the CaRMS match may appear to resolve the issue of underserved areas but are only exacerbating issues of long-term healthcare delivery in these areas. They distract us from addressing the true underlying causes for a lack of physician presence in rural areas.

One of the underlying issues for lack of retention in rural areas is the historically low interest in rural medicine at the medical student level. Most individuals who enter medical school are urban-born and urban-raised Canadians,<sup>15</sup> who have family commitments and familiarity with the city they grew up in, and therefore have a desire to stay in a similar urban environment. Furthermore, medical schools themselves are mostly located in larger urban centres and medical students grow accustomed to living in these cities during their time in medical school.

The creation of the University of British Columbia's (UBC's) distributed medical education model, which offers medical training sites in rural locations (Prince George, Kelowna) is an example of an approach to alleviate this issue. These sites offer a preference for selection of medical students who have a background of living or working in rural areas through a supplemental application that calculates a candidate's "rural suitability score."<sup>16</sup> Similarly, the

existence of the Northern Ontario School of Medicine also attracts rurally-born and rurally-raised Canadians to a school that trains students in a rural environment, with the prospect that they will continue their career in a rural area. Effort and trust should be placed into more initiatives such as these, which have been shown to work. In fact, data from the UBC Faculty of Medicine demonstrates that the distributed medical education model is having a positive impact on the supply of primary care physicians as well as rural physicians in British Columbia. Of all students trained in a rural setting at UBC (such as Prince George or Kelowna), 59% went into Family Medicine, and 66% pursued training in a rural setting.<sup>17</sup>

The issue with these initiatives is that, while more effective, they take time to display results, whereas a contract forcing relocation to an underserved is an immediate, but short-sighted, “guarantee” to secure physicians in places of need. In the grand scheme, however, focus should arguably be placed on initiatives that are sustainable and beneficial for all parties - both patients and future physicians.

**Concern 3:** In the context of medical student advocacy to increase residency spots across Canada, provincial governments may continue to tie new residency spots targeted at newly graduated CMGs entering the CaRMS match to ROS contracts, placing medical students in an increasingly difficult position.

As mentioned earlier, this strategy should be strongly discouraged as it takes advantage of medical students, who are already facing extreme pressures attempting to match to scant residency positions. It is well documented that medical students experience extreme burnout and higher rates of depressive symptoms and suicidal ideation compared to the general population.<sup>18, 19</sup> These types of contracts impact the ability of medical students to attain stability, to start families, and to create lasting roots in a community. The medical profession is already a career path that provides very delayed gratification and requires immense personal sacrifice. Adding an additional layer of complexity to medical training that requires relocation to an underserved area after residency only contributes further to burnout and delays career aspirations. Additionally, it may also serve to discourage already underrepresented groups from applying to medicine, if they cannot tolerate 9 years of uncertainty over their living situation (for example, those from low SES families supporting relatives, those with children, persons with disabilities, etc.).

In short, the need for more residency spots and the need for more physicians in rural areas are equally concerning, but nonetheless separate, issues which cannot be solved by the “quick fix” of a forced relocation contract.

## Recommendations

1. In any immediate future initiatives aimed at lobbying provincial governments for increased residency spots, medical student societies should seek support from their faculty, provincial, resident, and medical associations, and any necessary

regulatory bodies to present a unified stance discouraging the use of practice-location restricting contracts for newly graduated CMGs.

- a. Medical student societies should attempt to prioritize a response to any provincial government utilizing ROS contracts for newly graduated CMGs entering the CaRMS match by offering the perspectives outlined in this position paper.
  - b. Efforts from each medical student society should be placed on raising awareness to their wider student body of the disadvantages of ROS contracts and how they may be detrimental to future physicians and rural communities.
2. Advocacy efforts from medical student societies should focus on other strategies to increase physician recruitment to underserved areas, as well as novel approaches to provide rural areas with the same level of service as urban areas.
- a. This includes increased establishment and enrolment of students into medical education models that train medical students from rural communities within rural communities (such as UBC's distributed program or the Northern Ontario School of Medicine), which have shown to be effective in recruitment to underserved areas. Increased effort should be placed on immersive rural exposure during medical school consistently across all schools in Canada.
  - b. If any type of service agreement is to be considered, an optional, bursary-type incentive has been shown to work and would be more preferred rather than a contractual obligation tied to residency position funding.<sup>22</sup>
  - c. The usage of telemedicine or other innovative information technology to provide healthcare from a distance (including services such as [www.consultderm.com](http://www.consultderm.com)) should also be pursued more intensively. Further discussion on details of these technologies are beyond the scope of this paper, as this paper is intended to shed light on the disadvantages of ROS contracts targeted at newly-graduated CMGs, and to propose approaches to alternative solutions.

## **Acknowledgements**

Erin Marshall, Memorial University of Newfoundland, Class of 2021

Josée Malette, Northern Ontario School of Medicine, Class of 2020

Privia Randhawa, University of British Columbia, Class of 2021

Billy Zhao, University of British Columbia, Class of 2022

Reem Aziz, University of British Columbia, Class of 2022

## References

1. Canadian Institute for Health Information. Supply, Distribution and Migration of Physicians in Canada 2015 – Data Tables. Ottawa, ON: Canadian Institute for Health Information; 2016.
2. Bosco C, Oandasan I. Review of Family Medicine Within Rural and Remote Canada: Education, Practice and Policy. Mississauga, ON: College of Family Physicians of Canada; 2016.
3. Advancing Rural Family Medicine: The Canadian Collaborative Taskforce [Internet]. The Rural Road Map for Action: Directions. CFPC. 2017. [cited 2019 Apr 11]. Available from: [https://www.cfpc.ca/uploadedFiles/Directories/Committees\\_List/Rural%20Road%20Map%20Directions%20ENG.pdf](https://www.cfpc.ca/uploadedFiles/Directories/Committees_List/Rural%20Road%20Map%20Directions%20ENG.pdf)
4. Ontario to fund more residency positions for graduating doctors. [Internet] CBC News. 2018 [cited 2019 Aug 15]. Available from: <https://www.cbc.ca/news/health/residency-ontario-1.4623120>
5. CaRMS. Program Descriptions - First Iteration [Internet]. CaRMS. 2019 [cited 2019 Apr 11]. Available from: <https://www.carms.ca/match/r-1-main-residency-match/program-descriptions/>
6. Return of Service Contract - Dermatology [Internet]. University of British Columbia Faculty of Medicine Postgraduate Medical Education. 2019 [cited 2019 Apr 11]. Available from: <https://postgrad.med.ubc.ca/return-of-service-contract-dermatology-cmg/>
7. Audas R, Ross A, Vardy D. The use of provisionally licensed international medical graduates in Canada [Internet]. CMAJ; 2005 [cited 2019 Apr 11]. Available from: <http://www.cmaj.ca/content/173/11/1315.long>
8. Licence requirements for international medical graduates: Should national standards be adopted? *CMAJ* 2000;162(6):795-6.
9. Mathews M, Edwards A, Rourke J. Retention of International Medical Graduates Following Postgraduate Medical Training in Newfoundland and Labrador. *Healthcare Policy | Politiques de Santé*. 2008 Jul 21;2(2):62–9.
10. Gray DJP, Sidaway-Lee K, White E, Thorne A, Evans PH. Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality. *BMJ Open*. 2018;8(6).
11. Worrall G, Knight J. Continuity of care is good for elderly people with diabetes Retrospective cohort study of mortality and hospitalization. *Canadian Family Physician*.

2011 Jan;57(1):16–20.

12. Charter of Rights and Freedoms, Part 1 of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11.
13. Waldman V., et al. The Medical Services Commission of British Columbia. [Internet] Global Health & Human Rights Database; 1997. [cited 2019 Apr 12]. Available from: <https://www.globalhealthrights.org/health-topics/health-systems-and-financing/waldman-v-british-columbia-medical-services-commission/>
14. Rounds - August 21, 2015 [Internet]. Resident Doctors of BC. 2015 [cited 2019 Apr 11]. Available from: <https://residentdoctorsbc.ca/rounds-august-21-2015/>
15. Dhalla I, Kwong J, Streiner D, Baddour R, Waddell A, Johnson I. Characteristics of first-year students in Canadian Medical Schools. *Canadian Medical Association Journal*; 2002 Apr.
16. Rural and/or Northern Training Section [Internet]. University of British Columbia MD Undergraduate Program. 2016 [cited 2019 Apr 11]. Available from: <https://mdprogram.med.ubc.ca/2016/07/07/rural-andor-northern-training-section/>
17. Office of Education, Faculty of Medicine, UBC, 2019
18. Rotenstein LS, Ramos MA, Torre M, et al. Prevalence of Depression, Depressive Symptoms, and Suicidal Ideation Among Medical Students: A Systematic Review and Meta-Analysis. *JAMA*. 2016;316(21):2214–2236. doi:10.1001/jama.2016.17324
19. Glauser W. Medical schools addressing student anxiety, burnout and depression. *Canadian Medical Association Journal*; 2017 Dec.
20. Mathews M, Rourke JTB, Park Amanda. National and provincial retention of medical graduates of Memorial University of Newfoundland. *CMAJ*. 2006 ;175(4) :357-360.
21. Mathews M. Maria Mathews : Calling all country doctors. [Internet]. *National Post*. 2013 Feb. [cited 2019 Aug 15]. Available from : <https://nationalpost.com/opinion/maria-mathews-calling-all-country-doctors>
22. [Matthews M, Heath SL, Neufeld SM, Samarasena A. Evaluation of Physician Return-for-Service Agreements in Newfoundland and Labrador. \*Healthcare Policy\*. 2013; 8\(3\).](#)