

Analysis of the International Questionnaire Regarding the Evaluation of Foreign-Educated Professionals

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Le Consortium canadien des ordres
de sage-femmes / Canadian
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*Projet sur une nationale
d'évaluation de la
pratique sage-femme*

*National Midwifery
Assessment Strategy
Project*

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1.0 Introduction

The National Midwifery Assessment Strategy (NAS) project is a project of the Canadian Midwifery Regulator's Consortium (CMRC), an umbrella group of regulatory organizations in the five provinces where midwifery is currently regulated. The goal of this research project is to determine an efficient, effective, and fair pan-Canadian strategy for assessing internationally-educated midwives who wish to register to practice in a Canadian province or territory. The project is supported by Canadian midwifery associations and education programs and funded by Human Resources and Skills Development Canada and the member regulatory bodies of the CMRC. It commenced in the Fall of 2003 and will be completed in 2006.

Midwifery is a newly regulated profession in Canada, with only three small university-based education programs, and Canadian midwifery regulatory bodies must rely upon registering internationally-educated professionals (IEPs) to meet the current and future demand for midwifery services. Over the past decade, Canadian midwifery regulators have collaborated to develop competency-based prior learning assessment processes that recognize education and experience gained internationally. However, even with this cooperation, assessment standards and processes are not consistent throughout the country. By 2003, the CMRC realised that there was a critical need for a comprehensive and consistent national approach to assessment that could maximize the limited resources of current provincial regulators, support provinces that are not yet regulated in moving toward regulation and facilitate the entry-to-practice of internationally-educated midwives.

Unfortunately, as other regulated professions were only then responding to the same challenge, there were few models to follow. To begin developing the kind of practical systems approach desired by the CMRC, it was necessary to research nationally and internationally for innovative and integrated assessment models with potential applications for midwifery regulators in Canada. The NAS project was developed in response to this need.

This report presents data obtained via an International Questionnaire, one of the data collection tools used in the NAS project. Its goal was to acquire and analyze information from professional regulators, both domestically and internationally, about what assessment strategies and tools are currently being employed, what issues regulators are dealing with in the assessment of internationally educated professionals, and what innovations they have found to be helpful.

2.0 Methodology

The international questionnaire (Appendix A) was developed by the NAS research team with input from research advisors and the NAS steering committee, a group that includes representatives from each of the regulated provinces. The international questionnaire was structured with both open and closed ended questions to facilitate quantitative comparisons and to solicit information regarding specific criteria and tools utilized by health regulators when assessing internationally-educated professionals.

Due to the short timeframe available for this research, it was determined that it would be advantageous to develop the questionnaire in an on-line format as well as a paper-based format. The questionnaires' on-line format was offered using SurveyMonkey, a web-based survey distribution software. A cover letter, containing information about the survey and confidentiality (Appendix B), was also developed. Both were translated by the NAS project translator so that they were available in English and French.

The questionnaire was pre-tested by Canadian midwifery regulators in late September 2004. The initial test experienced some technical difficulties with the online survey delivery software, however after these technical problems were corrected, the survey was successfully tested and readied for distribution to selected recipients.

An initial invitation to participate in the survey was sent by either postal mail or email (where postal addresses were unavailable) in October and November 2004, to:

- a) all midwifery, nursing, medicine and pharmacy regulators in Canada;
- b) midwifery, nursing, medicine and pharmacy regulators in Australia, New Zealand, Belgium, Germany, France, the Netherlands, Switzerland, the United Kingdom; and the USA. This purposeful sampling was intended to ensure that we had information about regulatory processes that internationally-educated midwives have suggested we use as models;
- c) midwifery, nursing, medicine and pharmacy regulators in countries chosen randomly from regional groupings: Bulgaria, Denmark and Portugal (Europe); Puerto Rico and the U.S. Virgin Islands (Caribbean); Argentina and Uruguay (South America); Northern Mariana Islands, Guam, and Tonga (Pacific) ; Kazakhstan, Japan, Malaysia, Singapore, and Thailand (Asia); Syria (Middle East); Tunisia, Kenya and Namibia (Africa).

Participants were invited to respond on-line or via mail or fax.

As responses to the surveys began arriving we followed up on information provided by respondents in answer to our request for contact information regarding other pertinent regulatory bodies in their country or jurisdiction. With this information we were able to cross check our mailing list and ensure that the questionnaire was sent to the appropriate individuals and/or addresses.

An email reminder was sent in early December 2004, to every organization with email contact information. In late December 2004 and early January 2005 we continued to search and send out invitations as new contact information became available. Given initial sporadic responses from some world regions, we randomly selected additional countries from those regions and sent additional invitations to pertinent regulators in those countries where contact information could be located. These included Jordan, Democratic Republic of the Congo, South Africa and Zimbabwe.

In total, 365 English-language and 34 French-language surveys were sent to 110 jurisdictions representing 33 countries.

Completed questionnaires were received via the on-line system (Survey Monkey), email, fax, mail, and in one case verbally. Data was entered into a customized database. Quantitative data was analysed using queries in Microsoft Access 2002; while qualitative data was analysed via coding, in some cases with the use of NVivo software.

Issues and Limitations

We were unable to find a “worldwide” database for each profession that provided comprehensive up-to-date contact information. Given the relatively short period of time allotted to the questionnaire in this phase of the research, we had to rely heavily on Internet web sites and databases for email contact addresses. Where there was little information on the Internet, we contacted our own midwifery sources as well as professional associations in the regions in question for information about regulators in their regions.

Obtaining contact information proved to be more challenging when searching in developing nations where Internet and email access is limited, and in countries where resources were available in a language other than English or French. In many cases, contact persons and addresses listed on websites or other publications were unable to be interpreted, or were incorrect or incomplete.

Unfortunately, we know that not all email reminders went to the same person as the original mailed hard copy. The lack of the research team's fluency in more than French and English was mitigated to some extent by enlisting the temporary assistance of additional research assistants to help us locate appropriate contact information in two specific languages (Arabic and Spanish).

Another language-related challenge was related to lack of sufficient funds to translate the questionnaire into additional languages. The effect of the survey being available in only English and French is a factor that appeared to have some impact on the response rate. While about half of the countries that received questionnaires do not use English or French as an important locally-used language, only 25% of countries that responded fit this description.

The diversity of regulators and regulatory systems around the world (see below under "Findings") led to difficulties finding generic terminology for use in the questionnaire and ultimately led to differing interpretations of some key vocabulary used. For example, while some regulators use only one of the terms "registration" or "licensure" to indicate that a professional has met requirements for legal practice in their jurisdiction, a few regulators use both, each with a specific meaning and use. For example, the Pharmaceutical Council of Western Australia noted that "all are required to be registered. However, only those who wish to practice are required to be licensed."

In addition, certain questions were difficult to answer for some regulators. For example, we hadn't sufficiently taken into account the fact that many regulators have external organizations carry out the actual assessment activities. Because the questionnaire did not easily allow respondents to indicate when they should include those parts of the assessment that they have others do, some of the data was difficult to interpret. Where possible, the researchers followed up with respondents to confirm answers, did additional Internet research to further understand answers, and organized queries to take into account the use of external organizations for assessment.

Finally, many respondents did not fully complete the questionnaire so the response rate for specific questions is sometimes lower than the overall response rate. This particularly impacted the narrative questions. Where this difference is significant, this information is included with findings so that readers can appropriately interpret the findings.

2.1 Characteristics of the Respondents

Of the 399 surveys sent out, 157 were completed and returned (see Appendix C). This is a return rate of 40%. Surveys came from 72 jurisdictions in 16 countries (see Chart One). Responses were received from regulators of all four professions (see Chart Two).

In many countries there is one national body which acts as the professional regulatory authority. In such cases a single organization provided information for one or more of the professions that it regulates. By contrast, in Canada, the US and Australia, each province, territory or state has a separate regulator for each profession. In addition, the US generally had two separate regulators per state for midwifery (one for nurse-midwives and one for direct-entry or lay midwives). As a result we received comparatively high numbers of responses from these latter countries in relation to all others as a whole as is reflected in Chart One below.

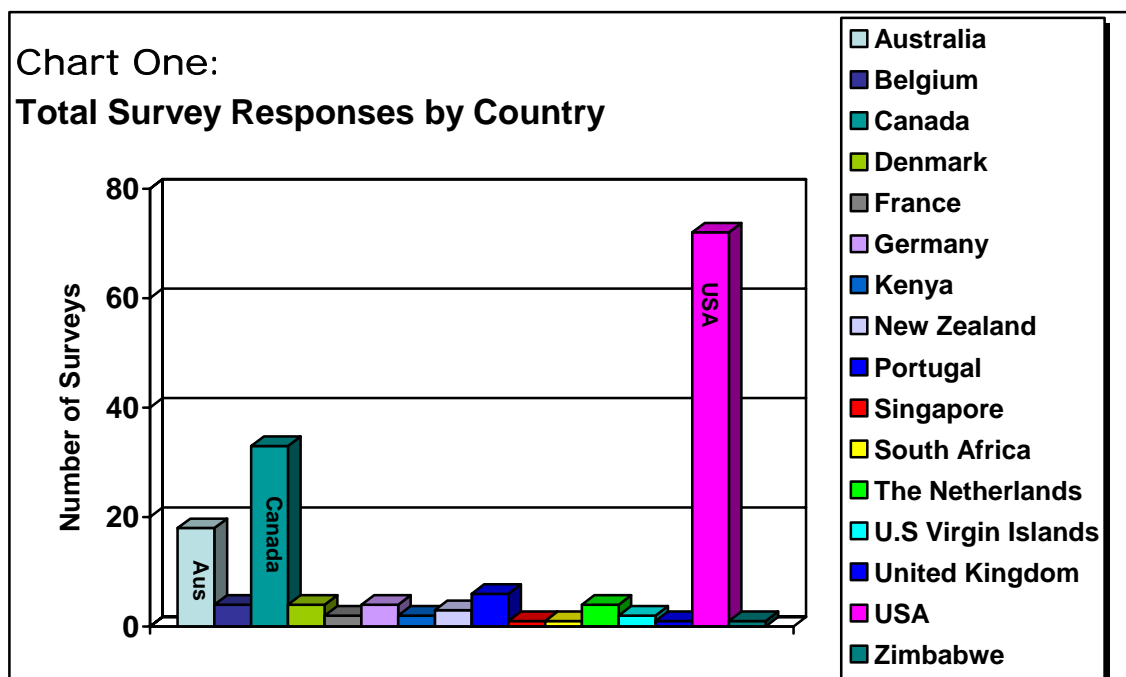


Chart One: Total Survey Responses by Country

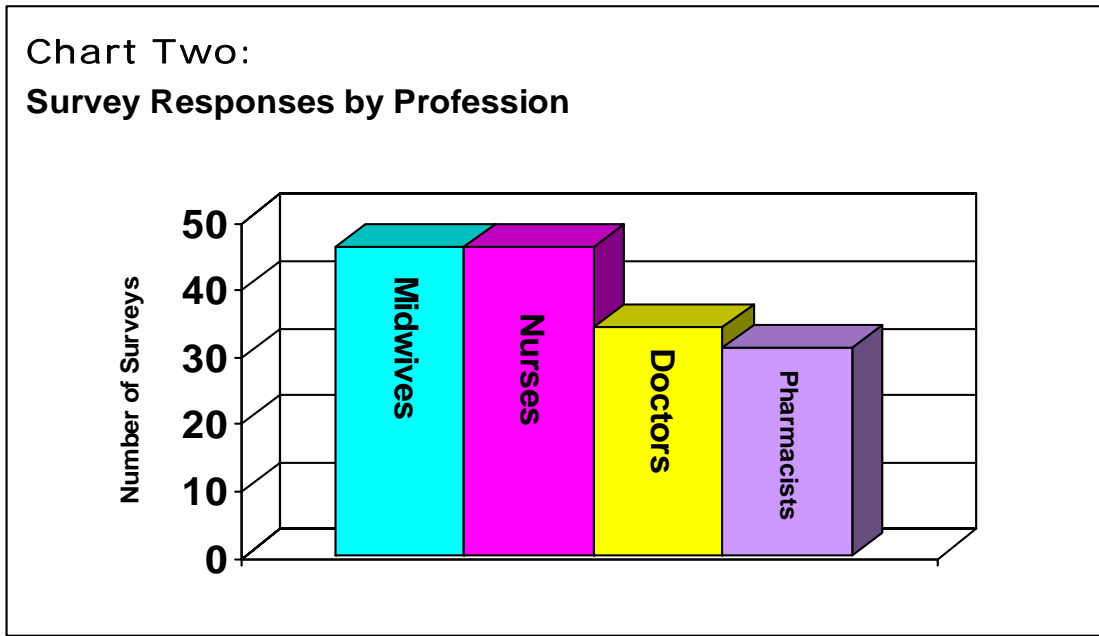


Chart Two: Survey Respondents by Profession

Respondents were asked to provide statistics regarding the number of applicants processed for registration in the past year. We hoped that this would provide useful context for understanding responses to certain questions, especially those regarding innovative initiatives that the CMRC may want to consider.

For the purposes of our analysis, regulators are considered small or large based on the number of applicants that are registered per year. Those that register under 99 applicants per year are deemed “small” and organizations that register over 3000 applicants per year are considered “large”.

As noted in Chart Three below, survey data indicates that large regulators tend to be those that regulate nursing. For example, the Nursing and Midwifery Council of the United Kingdom licenses applicants from four countries; England, Northern Ireland, Scotland and Wales with over 50,000 applicants registered per year.

Small regulators tend to be those that regulate midwifery. Midwifery regulators in Canada and lay midwifery regulators in the US tend to be smallest. For example, the College of Midwives of Manitoba registers under ten applicants in a year.

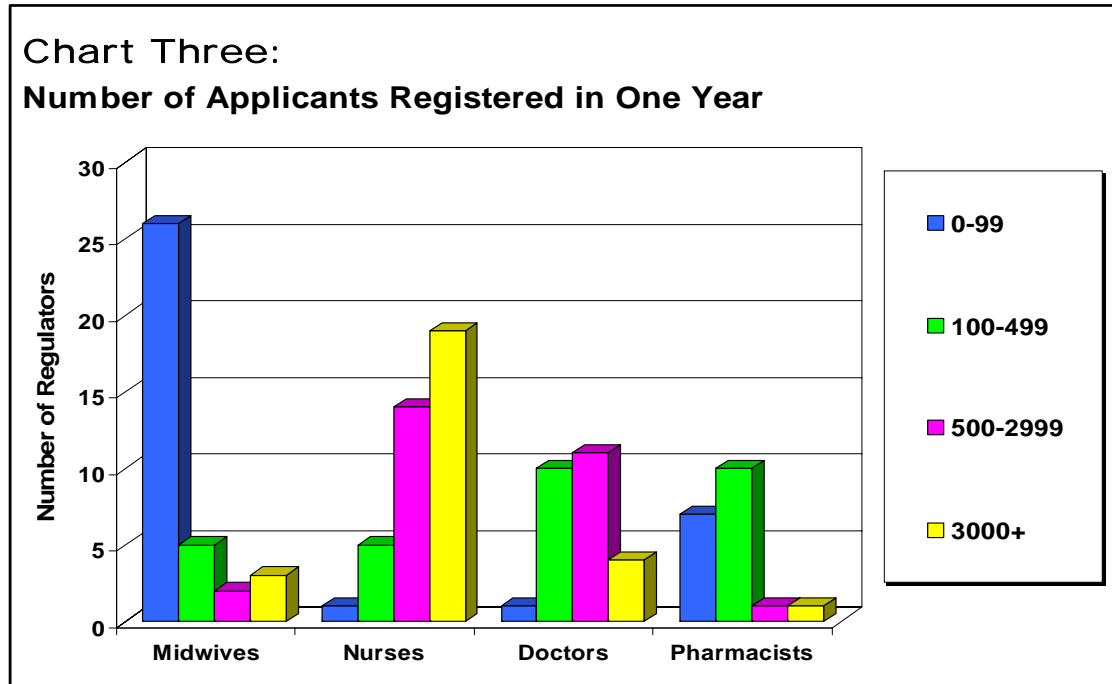


Chart Three: Number of Applicants Registered in One Year

Ninety-seven respondents provided information about how many IEPs they register in a year. Survey data indicates that medical regulators (See Chart Four below) have the highest percentage of internationally-educated professionals (IEPs) at 10-49% of a year's registrants. While the majority of midwifery regulators register 0-9% IEPs, data was quite variable and there was a notable number that register up to 90%. Those midwifery regulators which have fewer applicants overall, tend to show a greater percentage of IEPs.

Nursing and pharmacy regulators reported that the percentages of IEPs they register each year is generally quite small. Nursing regulators register between 0 and 29%, with the majority being less than 10%. Pharmacy regulators register even smaller numbers. Still it must be noted that small percentages may still indicate relatively large numbers of individuals – particularly in the case of nursing where most regulators are large

Chart Four:
Percentage of IEP Applicants in One Year

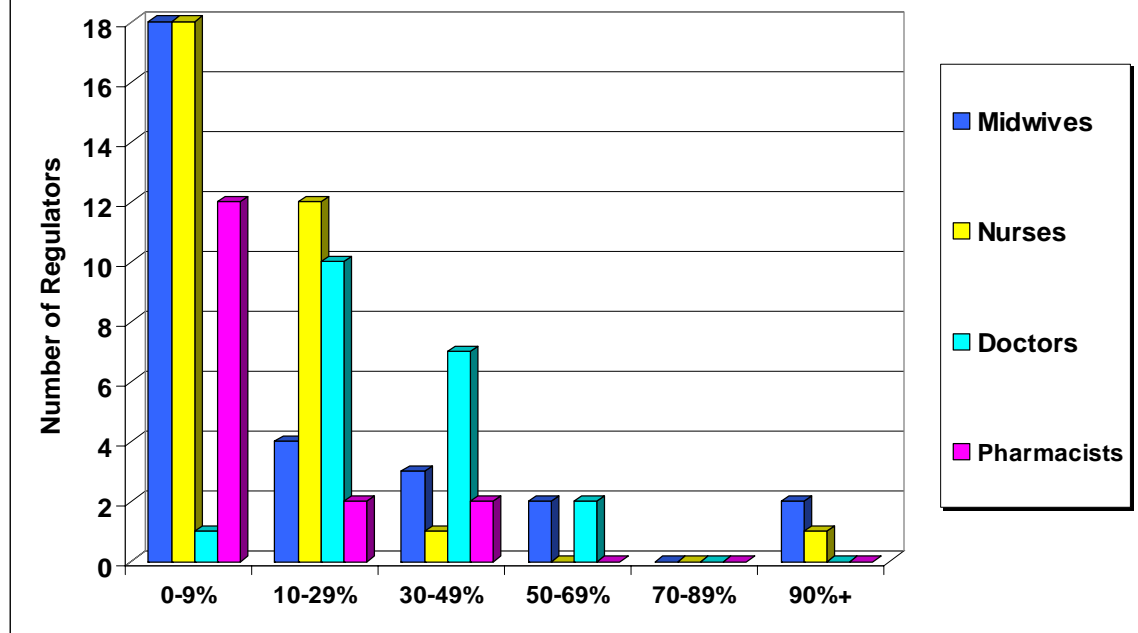


Chart Four: Percentage of IEP Applicants in One Year

3.0 Findings

3.1 Diversity of Regulatory Systems

One of the important findings of this research is that there is a wide variety of regulatory systems leading to different use and availability of resources for the assessment of IEPs, and different legal and logistical contexts within which regulators must work. All this has an impact on the registration criteria that must be met and on the specific evaluation required of internationally-educated professionals.

Regulators differ by:

- Number of professionals newly registered in a year – from under 10 to more than 50,000.
- Percentage of IEPs registered in a year – from 0-9% to 90%+.of all applicants
- How large an area they regulate – from several countries (e.g. United Kingdom) to a portion of a country (i.e. province, state, or territory).
- How many professions they regulate. Note that when a regulator was responsible for more than one profession, they tended to have subdivisions each responsible for a single profession thus in most cases we considered these subdivisions to each be a separate regulator for the purposes of this study.
- Whether there are divisions within a profession where the regulator has set different registration criteria. For example, the UK Nursing & Midwifery Council's Register requires that different criteria be met for general nursing, mental health nursing, learning disabilities nursing, and children's nursing, as well as for midwifery.
- Whether there are different registration categories. The Singapore Medical Council specified, for example, that they have a temporary registration category "for purpose of teaching, research or post grad study under approved training scheme etc. or lecturing". While they did not specifically detail the difference in registration criteria required and assessment process, the implication was that this is different from the standard process for full registration. Several other regulators echoed this possibility of a temporary registration. The New South Wales Medical Board (Australia) noted that they have a streamlined assessment process for doctors applying for a license to work in an "area of need".
- Whether there are inter-jurisdictional agreements that lead to different requirements dependent on the country of origin of the IEP. For example, European regulators have different criteria for IEPs from within the European Union and for those from outside.
- Whether there are differing requirements dependent on the setting in which the professional is working. For example, the Danish Medicines Agency only requires pharmacists to have a license "if the pharmacist

wants to work at a community pharmacy or a hospital pharmacy”. Several US regulators indicated that someone working for the federal government would not need to be registered. One regulator noted that there were different criteria for IEPs that would be going to work in an “area of need” within the country

- How much of the assessment of IEPs they carry out themselves, and how much of it is done by others. Many regulators require IEPs to undergo part or all of an assessment offered by an external organization.
- What terminology is used to describe their criteria and evaluation processes

In addition, at the time that this questionnaire was distributed, at least one country - Kazakhstan - appeared to have no national health professional regulatory system in place at all.

Although the extent of this diversity was not anticipated in the survey design, the research team carried out additional research and took the many differences into account in the interpretation of data for this report. It should be noted that researchers (and many respondents) have focused on the standard criteria and evaluation tools used for a comprehensive assessment of IEPs (and not on the streamlined process available to IEPs that meet specific criteria).

3.2 Criteria Required for Registration/Licensure

One of the questions that the questionnaire sought to determine was if there is any international consistency in the type of criteria that regulators require IEPs to fulfill to be registered to practice in their new jurisdiction. Respondents were asked to tick yes or no to three common criteria – professional education, clinical experience, and language fluency – as well as to provide narrative information on additional criteria that they may require.

Criterion: Professional Education

One of the criteria by which internationally-educated applicants are evaluated for registration or licensure is the successful completion of acceptable professional education. The responses to the questionnaire indicate that this is true in ninety-eight percent of cases (see Chart Five below).

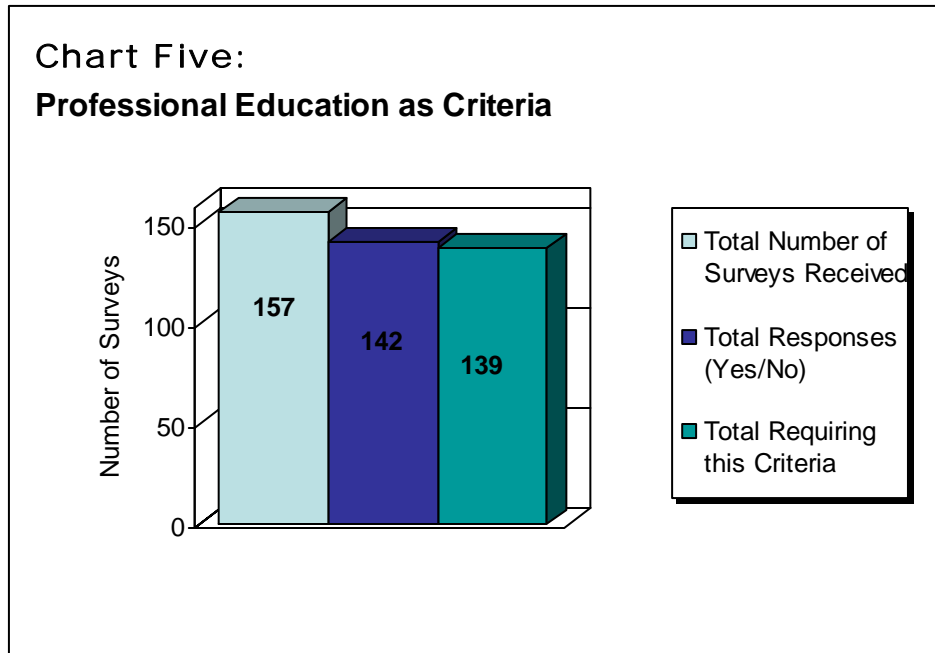


Chart Five: Professional Education as Criteria

However, of the 15 respondents who gave no response to this question most of them indicated in their narrative responses that holding professional education credentials is in fact one of the criteria that candidates must meet. Additional Internet-based research confirmed that all of the survey respondents require some type of formal or informal (e.g. apprenticeship) professional education.

The specific educational qualification required for registration or licensure differs by profession and by jurisdiction, but data does indicate that internationally-educated applicants are usually expected to have completed educational programs that are substantially equivalent to the professional education offered in the jurisdiction in which they wish to be registered.

The majority of professionals are required to have obtained post-secondary qualifications. However, some midwifery regulators in Canada and the US do not require post-secondary education but focus on ensuring that applicants have the requisite competencies for safe practice. For example, the College of Midwives of Manitoba describes their educational requirement to be “theoretical and clinical studies based on competencies covering all aspects of care from a primary care perspective” and they accept both formally and informally educated applicants. The Texas Department of State Health Services Midwifery Board indicates that applicants must be Certified Professional Midwives, a certification that requires passing an assessment of midwifery training (formal or apprenticeship-based) as well as a competency exam.

In summary, it appears that all regulators set professional education criteria requiring internationally-educated professionals to demonstrate an acceptable level of professional education in order to be considered for licensure.

Criterion: Specific Clinical Experience

Another requirement that some regulators set for registration is Specific Clinical Experience. Eighty-three percent of respondents stated that they do require some specific clinical experience (see Chart Six below).

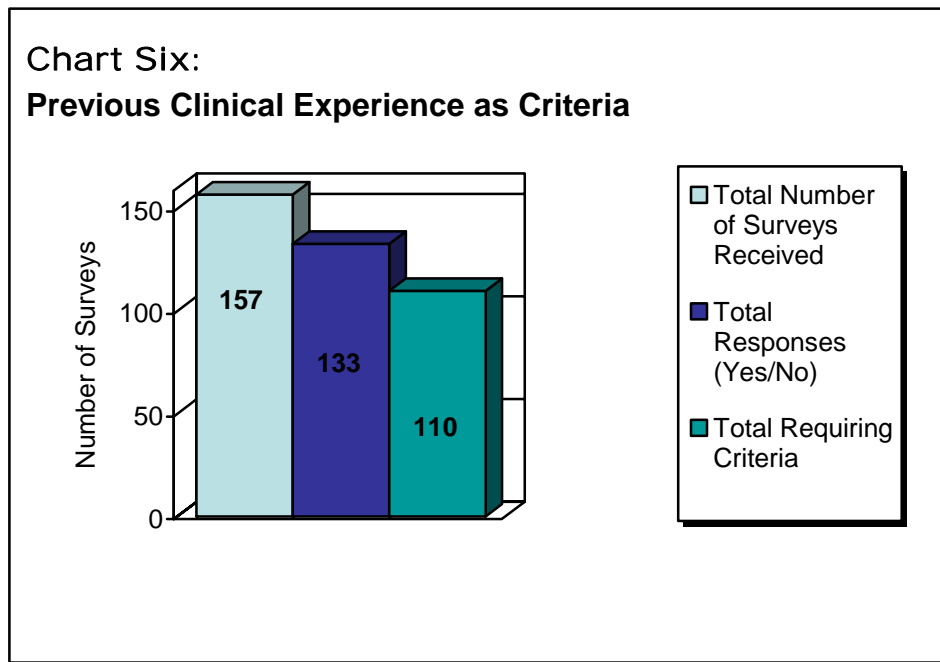


Chart Six: Previous Clinical Experience as Criteria

There were twenty-three respondents who ticked “no” when asked if they require specific clinical experience as a criterion for registration. Of those respondents only two did not provide narrative explanations as to why they do not require this criterion. The remainder indicated, in narrative explanations, that clinical experience is indeed a registration requirement. Likewise, of the 24 respondents who gave no response (left the tick box blank) twenty-three provided narrative responses confirming that they do in fact require specific clinical experience as a criterion for registration.

When clinical experience criteria were specified in narrative responses, they were generally expressed in one of the following ways:

- 1) participation in a specified education program (e.g. “3 years of postgraduate training”)
- 2) hours of clinical practice (ranging from 500 to 1500 hours)

- 3) currency of practice (e.g. "must have practiced in the past five years")
- 4) practice in specific clinical areas (e.g.: "OB, Ped, Medicine, Surgery, Psychiatric-Mental Health" and "60 births with 40 primary, 30 continuity of care, 10 home, 10 hospital")
- 5) a combination of the above (e.g. "1125 hours over 5 years")

We conclude then, that while there were some differing interpretations of this question, of those who responded, the vast majority required some type of clinical experience at some time in the candidate's professional and/or educational background in order to be eligible for registration.

Criterion: Language Skills

Eighty-five percent of respondents indicated that language skills are specified as a registration requirement (see Chart Seven below.)

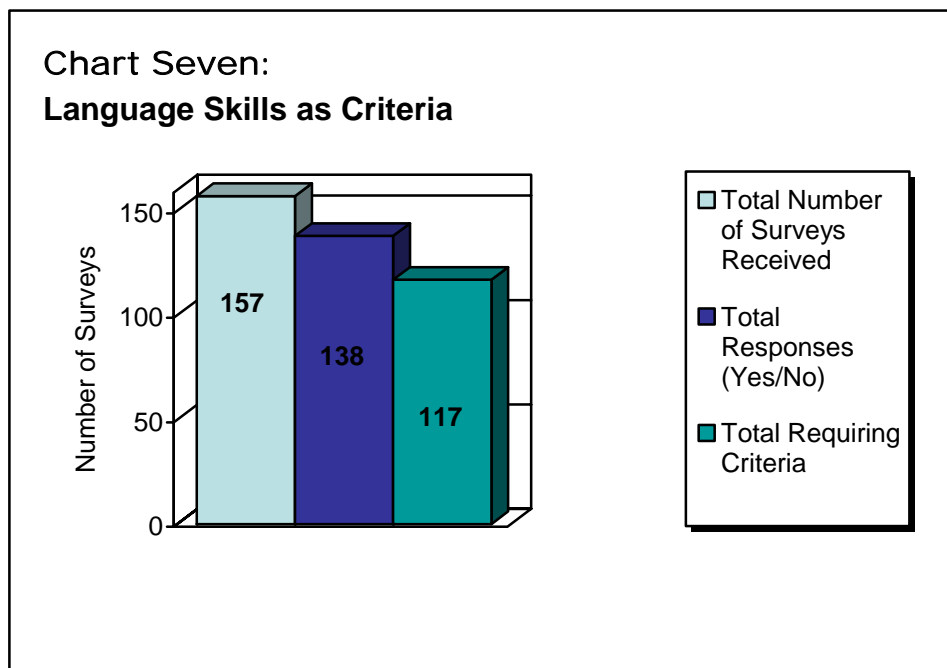


Chart Seven: Language Skills as Criteria

There were nineteen respondents who left this box blank and twenty-one respondents who checked "No" when asked if Language Skills are required for registration. During follow up research, we discovered that most of the regulators who have not set specific minimum language criteria assume that if a candidate passes professional exams or specific other parts of the assessment process they must, in fact, have sufficient language skills to practice. As the Alberta Midwifery Health Disciplines Committee explains, "The written exam is a good

way to screen out those who cannot write or understand English well, as it is timed and open-ended. The OSCE¹'s help with assessing the verbal skills.”

Of the regulators that rely on other parts of their assessment processes to assure language fluency, most regulators relied on a combination of written and practical exams. In other cases, regulators indicate that candidates must participate in a formal interview and demonstrate their fluency “to the satisfaction of the registrar” or another similar representative of the regulatory body.

There were a large number of acceptable language tests and required scores mentioned by respondents who require English language fluency. Those mentioned most often were Test of English as a Foreign Language (TOEFL), International English Language Testing System (IELTS), and Educational Commission for Foreign Medical Graduates (ECFMG) English testing (now part of their clinical exam). Where scores were mentioned, they also varied slightly. Test scores required by nursing regulators in the US appeared to be lower than others – usually 540 on TOEFL, 6.5 on IELTS - while most others tended to be about 580 on TOEFL and 7 on IELTS.

A few regulators who require other languages mentioned tests, such as the language exam offered by the Office québécois de la langue française (Canada), but no specific score levels were indicated.

While many regulators set certain test scores as their language fluency criteria, there were often separate criteria for those with the appropriate first language or with a lot of experience living, studying, and or working in that language. Respondents provided details about the criteria that IEPs must meet to obtain exemption from English fluency testing. Below are examples that indicate the range of exemption criteria and the fact that the data shows little consistency between regulators.

Exemption from English language testing if educated in English-dominant country for at least 4 years at a secondary or post-secondary institution in which the language of instruction was English AND lived in an English-dominant country for four of the six years immediately prior to the date of application.

If education /practice was in a country where English is the first language, [IEP would be] exempt from English language test, and if [the IEP had] practiced for 6 months in a country where English is the first language, they are exempt from the Competency Assessment Service

¹ Objective Structured Clinical Examination

Applicants may apply for exemption from English language testing and pre-registration program/supervised practice, if [they have] practiced as a registered nurse continuously for at least 12 months (no earlier than 6 months from time of application) in one of the following countries: United Kingdom, United States of America, Canada, Ireland, New Zealand.”

[Exemption from the English test] is usually based on the fact that the nurse has completed post basic education in the USA, UK, or Canada.”

In summary, we can conclude that all regulators do expect language fluency, even when specific criteria, such as test scores, are not set. This quote from the “Guidelines concerning the authorization of doctors trained outside Denmark” explains the sentiment well:

Every doctor must practice medicine carefully and conscientiously, and, to comply with this provision, doctors are required to be capable of responsible communication with patients, relatives, other hospital staff, etc.

Other Criteria

When asked if there were other criteria that internationally-educated professionals must meet to become registered or licensed, respondents provided a variety of responses.

Many regulators indicated that IEPs must demonstrate that they are physically and mentally fit to practice. For example, the Ordre des Pharmaciens (France) stated that IEPs need to provide “a clean criminal record check (no convictions for more than two years or for sexual crimes) and other good character criteria.” Many respondents indicate that they verify that IEPs are in good standing with the regulatory authority in the country of last practice (and in a few cases, in country of original registration as well). The Nurses Board of South Australia explained that “an investigation would be undertaken into criminal convictions declared. An investigation would be undertaken into any issues of competence or unprofessional conduct advised by the home country in the verification.”

Many respondents also confirmed that IEPs are required to have the requisite competencies (knowledge, skills, abilities) to safely practice their profession. These are assessed via examination or other competency-evaluation tools.

Other common registration criteria mentioned include:

- legal permission to work in the country or jurisdiction in which they are applying for registration (and in Germany, a job offer is also required);
- current lifesaving certifications e.g. “CPR² and NRP³ with intubation training”;

² Cardiopulmonary Resuscitation

- completion of a specific educational course or program designed to assist their integration into the new health care system and culture;
- completion of a period of supervised practice ranging anywhere from a few weeks to a number of months or years.

Several regulators noted that there were different registration criteria set for certain IEPs. For example, the College of Physicians and Surgeons of Ontario (Canada) notes that “there are numerous exemptions and extensions available for non-certified physicians. For example, highly qualified specialists may gain entry to practice without national certification after undergoing an assessment of their skills and knowledge”. The Wyoming Board of Medicine (USA) reports that their “board has discretion to license applicants who do not meet the statutory requirements but who have presented other credentials and qualifications equivalent to or exceeding the statutory criteria.”

3.3 Competency Evaluation Tools

The CMRC was interested in understanding what evaluation tools are used most commonly, and identifying if there are unique evaluation tools being used that should be studied for potential use by a pan-Canadian assessment strategy. Respondents were asked to check off which types of evaluation tools they utilize when assessing internationally-educated professionals for registration. The wide range of tools listed included: documentary evaluation (educational, clinical), exams (multiple-choice, short answer, essay, objective structured clinical examination, oral) and clinical observation. Respondents were also given the opportunity to provide information on any other evaluation tools that they may use.

³ Neonatal Resuscitation

**Chart Eight:
Evaluation Tools used by Respondents**

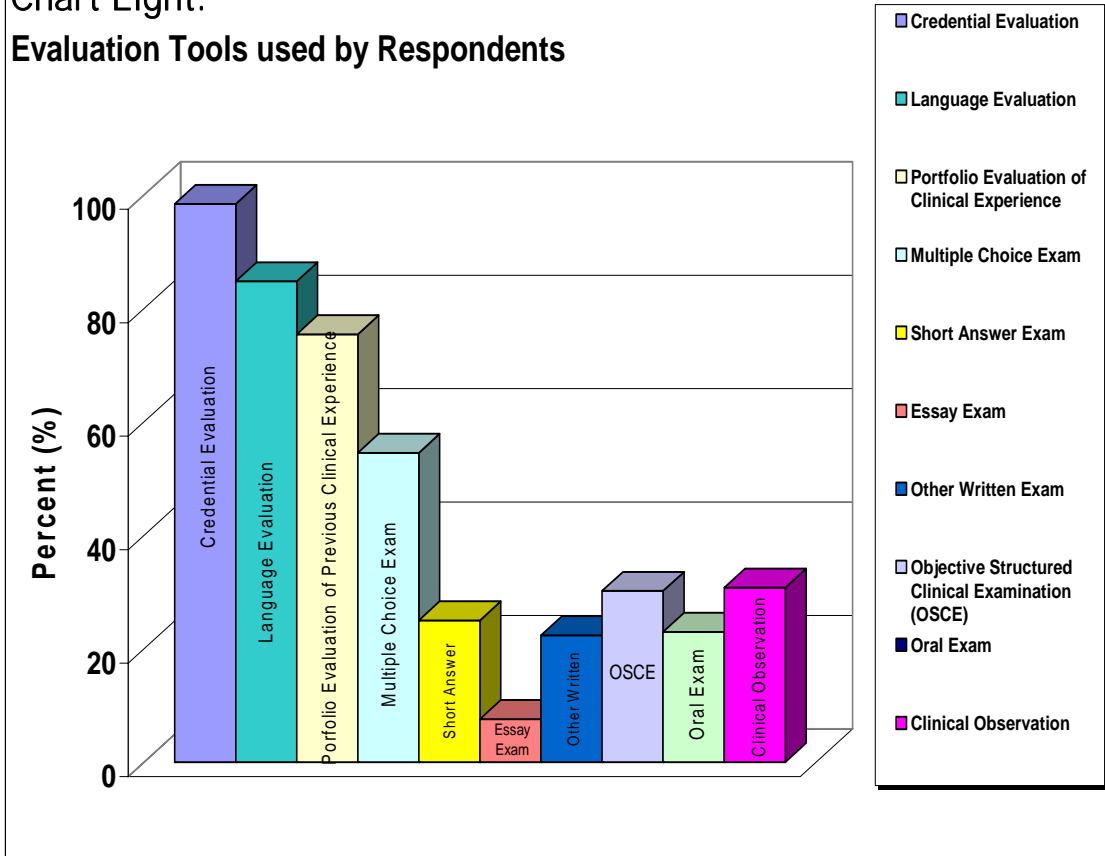


Chart Eight: Evaluation Tools Used by Respondents

Eighty percent of respondents answered this section although it is important to note that not all of these respondents ticked yes or no to each evaluation tool. In fact, there were many that left blanks in one or more categories. Narrative responses and additional research by the research team, indicates that in many cases, this was because the use of external bodies was not adequately accounted for in the survey design, making it confusing for respondents to know how best to answer this section (see below for further information on external processes). In spite of this problem, there are some trends that can be noted, and that additional research confirms.

All respondents indicate that they use at least one of the assessment tools listed in Chart Eight above. As the chart indicates, regulators commonly evaluate credentials and clinical experience via documentary evidence and many also use language evaluation tools.

According to survey data, multiple-choice is the most used examination type; over half of respondents reported the use of multiple-choice exams. Objective

Structured Clinical Exams (OSCE) and Clinical Observation were used by quite a few respondents, while fewer respondents used other listed exam types.

Several respondents clarified what clinical observation means for them. The College of Physicians and Surgeons of Ontario clarified that their practice assessment includes “chart review, clinical observation, and peer review”. Several regulators indicated that their clinical observation is carried out “via residency”. Others stated that periods of supervised practice or training is required.

Many regulators used more than one exam type. For example, of the 29 respondents who ticked yes to OSCE, 24 also use some type of written examination and all use some other type of evaluation tool. Only regulators in the USA reported using multiple-choice exams exclusively; all other respondents report using multiple-choice in combination with another examination tool, most commonly with an OSCE, oral examination, and/or clinical observation. With the exception of the Nurses Board of Victoria (Australia), respondents that require clinical observation also require another exam tool. The most common tool that is combined with clinical observation appears to be the OSCE.

One regulator, the Singapore Medical Council, reported that they do not currently use examinations but they are “reviewing the need to implement licensing exams in Singapore”.

Differences between professions

Chart Nine below indicates which evaluation tools are used by each profession. One key difference that can be noted here is the fact that 63% of medical regulators and almost 50% of pharmacy regulators reported using Objective Structured Clinical Exams (OSCE) while only 27% of midwifery regulators and 10% of nursing regulators use OSCEs to assess IEPs. Medical regulators also reported using short answer and essay exams more than other professions (nursing regulators reported no use of essays). Both medical and pharmacy regulators use oral exams and clinical observation more than midwifery and nursing regulators.

Several regulators clarified that different assessment tools were used with different IEPs. For example, the Danish National Board of Health stated that “previous clinical experience is taken into consideration if it covers lacks in the education.” The Nursing Council of New Zealand indicates that “competence

assessment [is required] if [IEP] is from a country where training is unknown, or [they are] from some known countries [such as] the Philippines.”

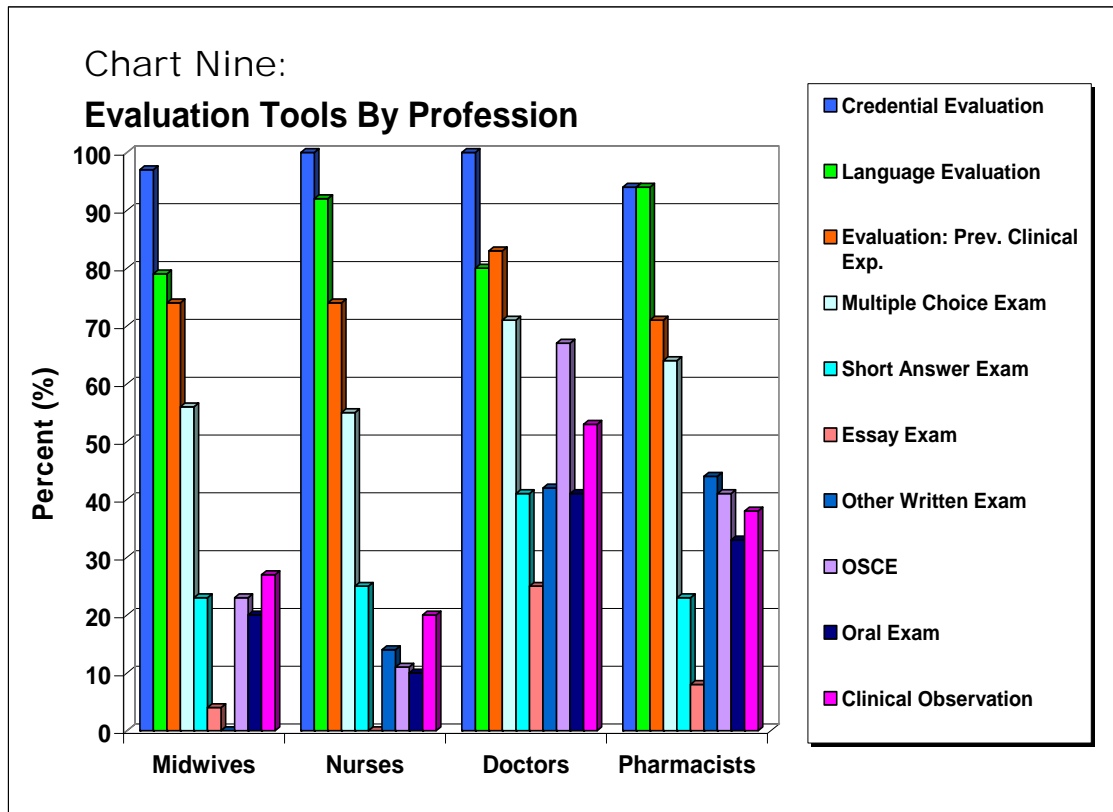


Chart Nine: Evaluation Tools by Profession

Differences between countries and regions

Only one notable geographic trend was identified in this research. It appears that the use of the Objective Structured Clinical Exam is used extensively only in Australia, Canada, New Zealand, and the USA. In fact, no respondents from other jurisdictions indicated that the OSCE is an evaluation tool used, although further Internet research does indicate that it is used by some regulators in other jurisdictions. For example, both the Health Professions Council of South Africa and the General Medical Council in the UK use the OSCE to assess internationally-educated doctors.

Other assessment tools

Respondents also provided a variety of responses when asked if they use any other evaluation tools to assess internationally-educated applicants.

A number of regulators explained that bridging or refresher programs, that include additional courses and/or clinical training, must be passed by IEPs.

A few regulators indicated that some kind of additional documentary review is carried out. For example:

- letters of recommendation from professional colleagues are reviewed
- licensure (and good standing) in previous jurisdiction(s) is validated

The College of Midwives of British Columbia described an optional evaluation tool offered to “highly qualified applicants”. Qualified IEPs submit an “Expanded portfolio” (a structured narrative by the IEP about what he or she knows and can do, along with documentary evidence to back it up) and take part in an interview with specially trained assessors for possible exemption from competency-based examinations.

The Prince Edward Island Pharmacy Board (Canada) noted that “after completing the required practice experience in PEI, we have a one week validated assessment tool that assesses whether or not [the IEP] has achieved the desired outcomes/competencies for entry to practice”.

External Evaluations

Some regulators had difficulty answering questions about evaluation tools as the questionnaire had not specified whether or not to include evaluation tools when external bodies carried out the assessment. As Chart Ten below indicates, a considerable number of respondents do require their IEPs to have some part of their assessment done via another organizational body. Further research indicates that this is an important trend worldwide.

To lessen the impact of this oversight in the questionnaire’s design, the research team carried out additional research, including web-based research on common national exams and follow-up contact with specific respondents. Data analysis queries were also designed to take into account this situation.

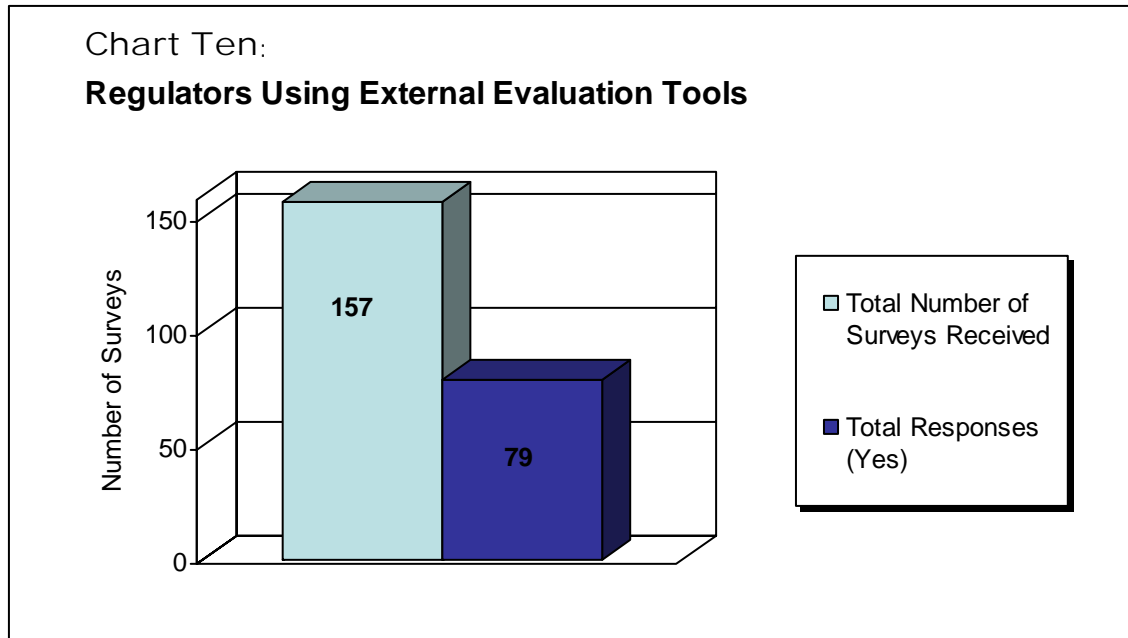


Chart Ten: Regulators Using External Evaluation Tools

There are a variety of ways in which external organizations participate in the assessment of IEPs. There appear to be regional trends, as described below.

North American pharmacy, nursing, and medical regulators require candidates to take examinations offered by national organizations. American midwifery regulators also tend to require candidates to pass a national exam. In the case of pharmacy and medical regulators as well as American nurses and sometimes midwives, IEPs' educational qualifications are also assessed by an external national organization.

In New Zealand and Australia, most regulators run their own national assessment processes, although required bridging programs are usually offered by external providers. The main exceptions to this trend are Australian pharmacy and medical regulators; they refer IEPs to national assessment services for both documentary evaluation and examinations.

In Europe, governmental bodies are often involved in the assessment of IEPs, either because the professions are directly assessed and regulated by government (usually via ministries of health) or because certain governmental bodies have been given a role in a specific aspect of the assessment of IEPs. For example, several European respondents reported that the Ministries of Health do credential evaluation while the regulating body administers examinations to those that pass the Ministries' assessment.

In a few cases, regulators do not have the resources to carry out any part of an assessment of IEPs themselves. Instead, they rely entirely on assessments by other regulators. For example, the Registered Nurses Association of the Northwest Territories and Nunavut, stated “[we] do not have capability to directly assess foreign grads. Therefore [IEPs] must apply to and be found eligible for registration in another Canadian jurisdiction before we can register them. “

One notable worldwide trend is a reliance by regulators on externally offered language fluency examinations.

3.4 When Gaps in Competency are Identified

Respondents provided information about possible outcomes for candidates when gaps in knowledge or skills are identified in the evaluation process. There was a range of responses as explained below.

Some regulators explained that a pass mark on an exam indicates no critical gaps and thus anyone who passes can be registered. Conversely, candidates that do not pass these exams cannot be registered. The Ordre National des Pharmaciens (France) explained that “The options are always at the initiative of the candidate . . . , it’s up to [the candidate] to remedy their gaps in order to succeed in passing the exam the next year.”

Other regulators described various outcomes that are required of candidates. These include:

- *Retakes of examinations*
- *Bridging programs*
Bridging, or “gap-filling programs” as they are sometimes called, usually last less than a year and they take a variety of formats. Typically they are profession specific courses designed to address discrete gaps. The focus is often on cultural competency, and modules or courses on key topics for the region are offered. Sometimes professional language training is provided at the high level required by the profession. Usually there are examinations integrated into the program that must be passed by applicants.
- *Clinical observation.*
This includes residency programs, as well as supervised practice with temporary or conditional registration attached. This allows the candidate the opportunity to address gaps in skills and knowledge while working in their field under supervision.
- *Approved courses or programs.*
Usually these are offered via a local educational institution. Sometimes they are offered via distance education or in a self-study

format. The regulator may identify certain individual courses that must be taken by the candidate, or they may require the candidate to complete up to an entire degree program.

3.5 Regulators Views of Success Factors for IEPs

The questionnaire asked respondents to identify factors that might have a positive or negative effect on an internationally-educated professional's chance of success in their assessment process. Sixty-nine respondents answered this section with narrative responses. An analysis of responses indicates that there are four areas that regulators agree are key factors for IEPs; these are described below.

Language Fluency

Fifty-one respondents from eight countries (Australia, Canada, Denmark, Kenya, New Zealand, Portugal, UK, and USA) and all four professions indicated that language fluency issues were very important factors that had an impact on an IEPs chance of registration in their jurisdictions. As the Prince Edward Island Pharmacy Board (Canada) stated, "Language is a definite problem, and also poses a safety issue." The College of Midwives of British Columbia (Canada) further explained that "not having the language skills sufficient to discuss research literature, pros and cons of different approaches to care and to carry out a consultation with another health professional is the most significant limiting factor [for IEPs]."

Respondents noted that having worked or studied in the language required gave IEPs a much better chance of success. The Queensland Nursing Council (Australia) explained that having completed education in a country where English is the first language is a positive factor for success and that any IEP who has not practiced in a country where English is the first language is referred to the Competency Assessment Service where they undergo additional assessment and may be required to take a bridging program.

Professional Education with similar curriculum

Sixteen respondents from four countries (Australia, Canada, New Zealand, and the USA) and all four professions indicated that an important positive factor for IEP's success was having completed a professional education program that was the same or very similar to the locally offered program (in the regulator's jurisdiction). The Washington Department of Health (USA) explained that "training that was dissimilar or lacking in current technology" has a negative effect on the outcome of an IEP's assessment for registration.

Familiarity with Culture and Health Care System

Twenty-two respondents primarily from all four professions in Canada, New Zealand, USA indicated that knowledge of the local culture and, in particular, its health system is a critical factor in an IEPs success. The New York State Board of Nursing (USA) summed this up by explaining that “a lack of knowledge of [the local] health care culture reduces the probability of successful completion of the [competency] exam.” The College of Midwives of BC (Canada) explained that “If an applicant comes from a culture where women are not offered choices about their care it can be difficult to adapt to a professional culture where the ethic of choice is a central tenet of care.”

Conversely, respondents indicated that if IEPs have practiced in a similar practice environment or model, they have a higher chance of success.

Regulators listed two key ways to improve the chances of success for those IEPs that come from countries with quite different models of practice and/or health care culture. The first is participation in a bridging program, such as the International Pharmacy Graduate Program (Ontario, Canada) or the Nursing Council of New Zealand Approved Competence Assessment Programs, which includes orientation to the local health care system and supervised practice.

If a bridging program is unavailable, a second way for IEPs to mitigate having been trained in vastly different cultural environments is to observe local practice through formal or informal clinical observations or through working in another, related health care role (such as a pharmacy assistant). The Ordre des sage-femmes du Quebec (Canada) stated that IEPs improved their chance of success through any type of increased understanding and familiarity with the local context: “experience in Quebec [has a positive effect], whether by having had personal maternity experience or by formally observing Quebec midwives in practice.”

Currency of Clinical Practice

Twenty-two respondents stated that currency of practice has an effect on the outcome of an IEP’s assessment. As noted above, some regulators have responded to this by setting currency of experience as a clinical experience criteria required for registration. The College of Physicians and Surgeons of Saskatchewan (Canada) states that they “will not license a physician who has not practiced in their field of practice within the past three years.” The College of Midwives of British Columbia states “while we have no hard data, we believe that

[current practice] has been helpful, especially if the current practice covers the full spectrum of care where competency is required for practice in BC.”

Other

A few respondents noted that clinical proficiency was important for an IEP’s success. Others noted that preparing for exams and having good test-taking skills enabled IEPs to be more successful in exams, and that being able to pass competency exams was an important factor in being successfully registered or licensed.

Seven US and Canadian medical regulators indicated that certification or licensure by others could be an advantage. For example, the Wyoming Board of Medicine (USA) notes that “licensure in other states is helpful though not necessary” and the College of Physicians and Surgeons of Saskatchewan (Canada) states that “certification by a body that has similar standards to Canada – American Board of Medical Specialties, for example – will be of assistance.”

Both the Singapore Medical Council and the Ordem dos Medicos (Portugal) indicated that any past professional misconduct would have a negative effect on the chance of a successful outcome. The Kenyan Ministry of Health noted that fraudulent documents are a prime reason an IEP’s lack of success in becoming registered in Kenya.

Finally, a number of respondents indicated that ensuring that criteria are met and paperwork is in order would make the assessment process more successful for IEPs. The New Zealand Council of Nurses simply said that a positive factor is the “prompt supply of all information”.

3.6 Issues Identified by Regulators

Forty-one respondents answered the question which asked regulators to identify issues for which they are seeking solutions. Five regulators indicated that they have no issues at the present time. Amongst the remaining responses, there were a number of challenges that were frequently mentioned. These are detailed below.

Cost

The cost to the regulator of maintaining and improving the assessment process (including internship) is an issue that many regulators face. Several regulators indicated that the cost to the applicant cannot realistically be high enough to cover all costs associated with the assessment and other sources of funds are

required. One stated that with such high costs, it is critical that applicants are well-screened and have a good chance of success. Others stressed that it is critical to have good planning and enough funds to have adequate capacity in the health care system for supporting new IEPs. One reminded us that if numbers of students in local professional schools are being increased, there will be decreased capacity for supporting IEPs unless there is also increased funding to the overall system

Credential Assessment

Issues related to assessing educational credentials were identified. Several respondents were concerned with ensuring the authenticity of documents received and one indicated that it is a challenge to find curriculum information from other countries. Another commented that “official transcripts not maintained cause tremendous problems for applicants.”

Language

Issues related to language proficiency were identified by regulators. The Nursing & Midwifery Council of the UK summarized the main issue by asking “what criteria do you employ to ensure that the overseas trained midwife is able to communicate on an acceptable level?” The Massachusetts Board of Registration in Nursing further specified that “TOEFL does not address English proficiency relative to the practice environment and identification of a minimum cut score that effectively protects the consumer.”

Cultural Integration

Cultural integration issues were identified as important. As the Ordre des Infirmiers and Infirmières du Québec explained “Nurses educated outside of Quebec find, like all new immigrants, challenges with integrating into a new society and culture”.

The number one issue that respondents identified is the need for upgrading and cultural integration educational programs that would allow IEPs to learn about the local health care system and model of practice, to practice appropriate language skills, and to upgrade skills and knowledge. For some this would be primarily a clinical-based internship; others described it more broadly as “a training program for foreign-trained applicants”. A few stated that a lack of internship locations was the major issue facing them.

Assessment Tools

Finally, respondents indicated a need to develop better assessment tools. Among other reasons, tools are needed to better assess clinical management skills, and to appropriately recognize an IEP's prior experience rather than relying on educational qualifications. One respondent indicated that "the entire area of assessment of fitness to practice requires close evaluation to determine proper tools for measurement."

Other

Other issues mentioned by respondents included:

- Immigration-related difficulties, including issues related to free circulation in the European Union
- Challenges owing to differing professional educational curricula and professional standards of practice around the world;
- Need to better communicate inter-jurisdictionally in order to standardize systems as much as possible, and to ensure that IEPs are in good standing in the jurisdiction in which they last practiced;
- Need to develop better outreach materials for providing information to IEPs.

One regulator commented that there is a need to "facilitate the licensure of [IEPs] – especially [through the reduction] of unnecessary barriers and cumbersome processes."

3.7 Innovative Initiatives

Regulators were asked to provide information about successful initiatives related to evaluating foreign-educated professionals. Forty-four respondents answered this question. Of these, ten answered "not applicable" or something equivalent.

Respondents tended to give little detail or to refer to websites or other general information so it was often unclear exactly what part of their process was innovative and the details as to how another organization might imitate it were missing. However, this section did provide interesting information about what respondents felt worked well for them.

The type of initiative listed most frequently (by fifteen respondents) was the use of external organizations to carry out some or all of the assessment process. In many cases the regulator recognized the results of a nationally offered exam, such as that offered by the National Council of State Boards of Nursing for nurses in the US. In other cases, private or publicly funded organizations were contracted to carry out credential evaluation services. In still others, the Ministry

of Health or public educational institutions offered bridging courses or workshops and/or supervised practice. Several respondents emphasized the importance of consistency and standardization across geographic areas (this is particularly relevant in Canada, US, and Australia, where regulation is by province/state). One regulator enthusiastically explained that the credential assessment service that assesses their applicants' credentials is "an excellent resource, knowledgeable about credentials, [they] ensure documents are bona fide." Another regulator summed up the importance for them of recognizing a national process rather than offering their own by saying, "[we have] very few applicants each year, so [the national] process ensures we don't have to train staff to evaluate rare yet complex applications from foreign-trained [applicants]."

Fifteen respondents were also enthusiastic about bridging programs and/or supervised practice or internships for ensuring the success of internationally-educated professionals in their jurisdictions. Several stated that they have instituted new programs that include both theoretical and skills education as well as some form of supervised practice. For example:

The Nursing & Midwifery Council of the UK is putting into place this September 2005 a new assessment process for IEPs that will incorporate a 20-day education program as well as supervised practice for three to nine months.

The College of Midwives of Ontario recognizes graduates from the International Pre-Registration Program, a nine-month bridging program that integrates education and assessment, including a period of supervised practice.

The College of Physicians & Surgeons of BC commented that the St Paul's International Medical Graduate program, incorporating a six month pre-residency program prior to the standard two-year residency for BC doctors, has been successful over the last ten years. A new three-month educational program at St Paul's was recently launched to assist additional IEPs to become "more marketable" for obtaining a residency.

Flexibility in the assessment process was mentioned by several respondents as a successful aspect of their processes. The Queensland Nursing Council did a major study in 1999 out of which their Competence Assessment Service was established. It provides IEPs with the option of Challenge exams and/or of attending educational modules designed to orient them to working in Australia. The College of Midwives of BC stated that they offer IEPs a "flexible multi-staged process that can be completed in less than one year or done over two or three years. Individual portfolio assessments and exams identify competency gaps so that supervision requirements can be individualized. [There is also an] option that allows highly qualified applicants to apply for exam exemption and reduces their need to travel to Canada more than once before registration." The College

of Physicians and Surgeons of Ontario commented that “we have been focusing many efforts on different types of assessment . . .”

A handful of respondents emphasized that being able to distinguish authentic documents from fraudulent ones was a key success. Others mentioned the importance of prior learning assessment programs. One regulator commented that a reciprocity agreement between their country and another was very successful. One stated that “competency-based assessment (OSCEs)” was successful. One emphasized that assessment by experienced practitioners was important.

Many other respondents referred the research team to their websites where the assessment processes for IEPs are explained in full. Presumably this indicated that they feel that their processes are successful initiatives worthy of being looked at more closely by our research team. A review of these websites and other data collected in this questionnaire indicates that assessment processes generally include:

- Language assessment (usually first)
- Documentary assessment, including credential evaluation
- Written exam (usually multiple choice)
- Clinical/practical exam (often OSCE)
- Bridging program and/or Supervised practice

4.0 Conclusions

A major finding of this research is that there is a tremendous amount of diversity in terms of how regulation of professionals is organized and carried out. There is often more than one route to registration for IEPs wanting to register in a given jurisdiction depending on factors such as where the IEP is coming from or where they are planning to work.

The majority of regulators worldwide expect applicants to meet professional education, clinical experience, and language criteria. Specific criteria do vary by regulator though no major differences were identified. A variety of additional criteria were identified by respondents. Some of these, such as fitness to practice, are expected by many respondents (additional Internet research suggests that most if not all regulators set this criteria). Others, such as the requirement of a job offer prior to registration, are less common criteria.

A wide variety of evaluation tools are used by respondents, and all use at least one tool. While there were some noticeable trends, particularly with regard to OSCE use, there was a wide diversity in terms of what evaluation tools and combinations of tools were used. Respondents described a few innovative tools, including bridging programs (with integrated assessment), a portfolio & interview-based assessment, and a practice assessment week. Many regulators rely on external organizational bodies to offer all or part of the evaluation of an IEP.

When gaps in competency are identified there are various outcomes for IEPs, Depending on the circumstances and the regulator, they may be required to retake examinations, participate in bridging programs and/or clinical observation (supervised practice), or take specific courses or educational programs (including a full degree program).

When asked to identify factors that positively or negatively impacted an IEP's assessment, respondents consistently identified language fluency as an important, and often the most important factor. They also noted that the content of an applicant's professional education program, their familiarity with the new culture and health care system, and the currency of their clinical practice were important factors. A few respondents stated that certification or licensure by others could be an advantage, and several mentioned that previous unprofessional conduct (including submission of fraudulent documentation) would be definite negative factors.

Issues faced by regulators are remarkably consistent and include the high cost of assessing IEPs which cannot be reasonably borne by the applicant, difficulties in obtaining appropriate information for evaluating foreign credentials, challenges in testing language fluency for the professional environment, and the need to develop better assessment tools. Regulators noted that cultural integration issues are important as IEPs do not perform well in exams or practice when they are unfamiliar with the local culture and health care system. A variety of other issues were noted by small numbers of regulators, such as the need for better outreach materials.

The most common innovations presented by respondents are the use of external organizations for some or all of the evaluation of IEPs and the offering of bridging programs to address gap-filling and cultural integration issues. Other innovations include ensuring flexibility within the evaluation process for each IEP, distinguishing the authenticity of documents received from IEPs, and having evaluation processes that include a combination of different evaluation tools.

There were few truly unique innovations discernable in the data but it is clear that while the broad categories are not unique, it is quite possible that there are innovations in the details. Unfortunately this survey was not able to capture that level of data.

5.0 Recommendations for the CMRC

The research data indicates that Canadian midwifery regulators are requiring similar criteria of IEPs and employing similar evaluation tools as other professional regulators worldwide. The issues and IEP success factors identified in this report are consistent with those identified by the CMRC in the NAS Developmental Phase Report. Of the innovative practices noted by respondents all are being undertaken by at least one Canadian midwifery regulator at this time.

Specific recommendations supported by this report include:

1. Consider the potential advantages of using externally offered evaluations. In particular, the feasibility of developing a national midwifery examination should be explored.
2. Investigate the impact of other regulators wishing to rely on assessments offered by CMRC members. The final national midwifery assessment strategy must take into account provinces and territories that don't have the candidate numbers to be able to develop and offer their own evaluation processes.
3. Develop a pan-Canadian bridging program that would include cultural competency training, specific gap filling courses, and supervised clinical practice.
4. Create opportunities for second language learners to master the required language fluency to the level required by Canadian midwives.

Appendix A – Questionnaire

Questionnaire Regarding the Evaluation of Foreign-Educated Professionals

The purpose of this questionnaire is to determine what types of assessment methods are being used internationally for the assessment of foreign-educated professionals.

SECTION ONE: About your Organization

This section identifies who is responding to this questionnaire and who registers or licenses professionals to practice in your area.

1. What is the name of your organization?

2. Please identify whether your organization registers or licenses the following foreign-educated professionals (check all that apply).

Midwives	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nurses	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Doctors	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pharmacists	<input type="checkbox"/> Yes	<input type="checkbox"/> No

3. If you checked **yes** to any of the foreign-educated professionals identified in question 2 above, what is the country, province, or state for which you have the authority to register or license these professionals to practice?

4. If you checked **yes** to any of the foreign-educated professionals identified in question 2 above, are there any categories within those professions that are **not** required to be registered or licensed to practice?

Yes **No**

5. If there are any categories within those professions that are not required to be registered or licensed to practice, please explain:

6. If you checked **no** to any of the foreign-educated professionals identified in question 2 above, please provide the name of the organization that does register or license them, and contact information if that is available.

SECTION TWO: Assessment and Evaluation Tools

This section identifies criteria for registration or licensure, and evaluation tools used to assess the competencies of foreign-educated professionals.

7. What criteria must foreign-educated applicants meet to be registered or licensed?

<i>Criteria</i>	
a. Professional Education	Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Specific Clinical Experience	Yes <input type="checkbox"/> No <input type="checkbox"/>
c. Language Skills	Yes <input type="checkbox"/> No <input type="checkbox"/>

8. What is the minimum requirement for the criteria identified in the above question?

a. Professional Education _____

b. Specific Clinical Experience _____

c. Language Skills _____

9. Are there other criteria that foreign-educated applicants must meet to be registered or licensed?

Yes

No

10. If there are other criteria that foreign-educated applicants must meet to be registered or licensed, please explain:

11. How are foreign-educated applicants assessed?

<i>Evaluation Tools</i>	
Evaluation of Educational Credentials	Yes <input type="checkbox"/> No <input type="checkbox"/>
Evaluation of Language Competency	Yes <input type="checkbox"/> No <input type="checkbox"/>
Evaluation of Previous Clinical Experience via Documentary Evidence (e.g. letters from supervisors, student case books, etc.)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Multiple Choice Written Examination	Yes <input type="checkbox"/> No <input type="checkbox"/>
Short Answer Written Examination	Yes <input type="checkbox"/> No <input type="checkbox"/>
Essay Written Examination	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other Written Examination: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Objective Structured Clinical Examination	Yes <input type="checkbox"/> No <input type="checkbox"/>

16. Are there factors that have a **negative** effect on the outcome of a foreign-educated applicant's evaluation (for example, lack of language skills, little knowledge of local health care culture) that decrease the likelihood of the applicant passing assessments or meeting your requirements?

Yes **No**

17. If there are factors that have a negative effect on the outcome of a foreign-educated applicant's evaluation, please explain:

18. Are any foreign-educated applicants able to gain exemption from all or part of your evaluation?

Yes **No**

19. If any foreign-educated applicants are able to gain exemption from all or part of the evaluation, please explain:

20.. What happens if gaps in knowledge or skills are identified in the evaluation process?

Applicant is required to obtain a local professional qualification by completing a professional education program	Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/>
Applicant is referred to a specific educational program designed to upgrade their professional skills, knowledge, and/or experience	Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/>
Applicant is required to complete specific courses	Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/>

Applicant is supervised for a period of time	Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/>
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21. Are there any other options for applicants that have had gaps in knowledge or skills identified in the evaluation process?

- Yes** **No**

22. If there are other options for applicants that have had gaps in knowledge or skills identified in the evaluation process, please explain:

For the next three questions, please provide information on the professions that your organization registers or licenses.

SECTION FOUR: Statistical Summary

This section identifies numbers of applicants in your country, province or state.

23. What is the **total** number of applicants for registration in the last year?

Midwives	<input type="checkbox"/> 0-99 <input type="checkbox"/> 100-499 <input type="checkbox"/> 500-2999 <input type="checkbox"/> 3000+ <input type="checkbox"/> don't know
Nurses	<input type="checkbox"/> 0-99 <input type="checkbox"/> 100-499 <input type="checkbox"/> 500-2999 <input type="checkbox"/> 3000+ <input type="checkbox"/> don't know

Doctors	<input type="checkbox"/> 0-99 <input type="checkbox"/> 100-499 <input type="checkbox"/> 500-2999 <input type="checkbox"/> 3000+ <input type="checkbox"/> don't know
Pharmacists	<input type="checkbox"/> 0-99 <input type="checkbox"/> 100-499 <input type="checkbox"/> 500-2999 <input type="checkbox"/> 3000+ <input type="checkbox"/> don't know

24. What percentage of these applicants were **educated outside of your country** ("foreign-educated") in the last year?

Midwives	<input type="checkbox"/> 0-9% <input type="checkbox"/> 10-29% <input type="checkbox"/> 30-49% <input type="checkbox"/> 50-69% <input type="checkbox"/> 70-89% <input type="checkbox"/> 90%+ <input type="checkbox"/> don't know
Nurses	<input type="checkbox"/> 0-9% <input type="checkbox"/> 10-29% <input type="checkbox"/> 30-49% <input type="checkbox"/> 50-69% <input type="checkbox"/> 70-89% <input type="checkbox"/> 90%+ <input type="checkbox"/> don't know
Doctors	<input type="checkbox"/> 0-9% <input type="checkbox"/> 10-29% <input type="checkbox"/> 30-49% <input type="checkbox"/> 50-69% <input type="checkbox"/> 70-89% <input type="checkbox"/> 90%+ <input type="checkbox"/> don't know

Pharmacists	<input type="checkbox"/> 0-9% <input type="checkbox"/> 10-29% <input type="checkbox"/> 30-49% <input type="checkbox"/> 50-69% <input type="checkbox"/> 70-89% <input type="checkbox"/> 90%+ <input type="checkbox"/> don't know
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25. What percentage of the **total number of foreign-educated** applicants were successful in obtaining registration or licensure to practice in the last year?

Midwives	<input type="checkbox"/> 0-9% <input type="checkbox"/> 10-29% <input type="checkbox"/> 30-49% <input type="checkbox"/> 50-69% <input type="checkbox"/> 70-89% <input type="checkbox"/> 90%+ <input type="checkbox"/> don't know
Nurses	<input type="checkbox"/> 0-9% <input type="checkbox"/> 10-29% <input type="checkbox"/> 30-49% <input type="checkbox"/> 50-69% <input type="checkbox"/> 70-89% <input type="checkbox"/> 90%+ <input type="checkbox"/> don't know
Doctors	<input type="checkbox"/> 0-9% <input type="checkbox"/> 10-29% <input type="checkbox"/> 30-49% <input type="checkbox"/> 50-69% <input type="checkbox"/> 70-89% <input type="checkbox"/> 90%+ <input type="checkbox"/> don't know
Pharmacists	<input type="checkbox"/> 0-9% <input type="checkbox"/> 10-29% <input type="checkbox"/> 30-49% <input type="checkbox"/> 50-69% <input type="checkbox"/> 70-89% <input type="checkbox"/> 90%+ <input type="checkbox"/> don't know

SECTION FIVE: Initiatives

This section identifies other initiatives and issues related to the assessment of foreign-educated applicants.

26. The Canadian Midwifery Regulators Consortium is looking for innovative, fair, and effective tools for evaluating foreign-educated midwives who wish to practice their profession in Canada. Please describe initiatives that you have found to be successful.

27. Are there any outstanding issues for which you are seeking solutions?

Follow-up Information

This section provides contact information and requests written information, if available.

28. Would you like a copy of the report of survey results?

Yes

No

29. Name and email address to send it to:

30. May we contact you with questions of clarification?

Yes

No

31. Name and contact information:

If you are able to attach written materials related to this topic, we would be happy to receive them. Please send to:

Wendy Martin
Project Coordinator & Researcher
Canadian Midwifery Regulators Consortium
c/o College of Midwives of BC
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Vancouver, BC V6H3N1 Canada
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Appendix B – International Questionnaire Cover Letter

RESEARCH INFORMATION

FOR

MIDWIFERY, ALLIED HEALTH, AND MEDICAL ORGANIZATIONS PARTICIPATING IN THE RESEARCH STUDY

The **Canadian Midwifery Regulators Consortium** would like to invite your organization to participate in the following research study:

EVALUATION OF FOREIGN-EDUCATED PROFESSIONALS: A COMPARATIVE STUDY OF 25 COUNTRIES

Lead Researcher: Wendy Martin, Project Coordinator, CMRC

PROJECT PURPOSE

The purpose of this questionnaire is to obtain information on how regulators around the world assess the qualifications of applicants that have been educated outside their country.

This research project is part of a larger project entitled the National Midwifery Assessment Strategy (NAS) which aims to seek information to assist with the development of a national strategy for evaluating the competencies and credentials of foreign-educated midwives who wish to practice in Canada.

YOUR INVOLVEMENT

This questionnaire should take approximately 25 minutes to complete.

This questionnaire is also available in email format at the following internet link:

<http://www.surveymonkey.com/s.asp?u=9148562222>

If your organization agrees to participate in this study, please fill out the questionnaire enclosed or that which is accessible on-line via the link indicated above. The information requested is generally public information, however be assured that all information containing personal characteristics will be kept secure and will be shredded at the termination of this project.

Your participation in this research project is entirely voluntary. If you wish to withdraw while the study is in progress, you are free to do so without reprisal, in any form. If you wish to receive the results of the research, please contact the Lead Researcher, Wendy Martin.

INCENTIVE

Organizations that participate in this research will receive a summary of the results, if requested. Copies of the international directory of health regulators may also be available.

Please address all correspondence to:

Wendy Martin
Canadian Consortium of Midwifery Regulators
c/o College of Midwives of British Columbia
F503-4500 Oak Street,
Vancouver, BC
V6H 3N1
Canada
Telephone: 604-875-2643
Email: plea@cmbc.bc.ca

Appendix C – List of Respondents

List of Respondents

Organization	Jurisdiction	Country	Profession reporting on
Nurses Board of the ACT	Australian Capital Territory	Australia	Nurses & Midwives
New South Wales Medical Board	New South Wales	Australia	Doctors
Nurses & Midwives Board of New South Wales	New South Wales	Australia	Nurses & Midwives
Pharmacy Board of New South Wales	New South Wales	Australia	Pharmacists
Nurses & Midwives Board of New South Wales	New South Wales	Australia	Nurses & Midwives
Queensland Nursing Council	Queensland	Australia	Nurses & Midwives
Nurses Board of South Australia	South Australia	Australia	Nurses & Midwives
Nurses Board of Victoria	State of Victoria	Australia	Nurses & Midwives
Pharmaceutical Council of Western Australia	State of Western Australia	Australia	Pharmacists
Nursing Board of Tasmania	Tasmania	Australia	Nurses & Midwives
Medical Practitioners Board of Victoria	Victoria	Australia	Doctors
Nurses Board of Western Australia	Western Australia	Australia	Nurses & Midwives
Commission Medicale Provinciale au Hainaut	Hainaut	Belgium	All four
Alberta Midwifery Health Disciplines Committee	Alberta	Canada	Midwives
Alberta College of Pharmacists	Alberta	Canada	Pharmacists
Alberta Association of Registered Nurses	Alberta	Canada	Nurses
College of Physicians & Surgeons of Alberta	Alberta	Canada	Doctors
College of Midwives of BC	British Columbia	Canada	Midwives
College of Pharmacists of British Columbia	British Columbia	Canada	Pharmacists
College of Physicians & Surgeons of BC	British Columbia	Canada	Doctors
College of Midwives of Manitoba	Manitoba	Canada	Midwives
College of Registered Nurses of Manitoba	Manitoba	Canada	Nurses
The Manitoba Pharmaceutical Association	Manitoba	Canada	Pharmacists
College of Physician & Surgeons of Manitoba	Manitoba	Canada	Doctors
College of Physicians & Surgeons New Brunswick	New Brunswick	Canada	Doctors
New Brunswick Pharmaceutical Society	New Brunswick	Canada	Pharmacists
Nurses Association of New Brunswick	New Brunswick	Canada	Nurses
Association of Registered Nurses Newfoundland & Labrador	Newfoundland & Labrador	Canada	Nurses
Registrar, Professional Licensing, Dept. of Health & Social Services	North West Territories	Canada	Midwives, Doctors & Pharmacists

Organization	Jurisdiction	Country	Profession reporting on
Registered Nurses Association of NWT & Nunavut	North West Territories	Canada	Nurses
College of Physicians & Surgeons of Nova Scotia	Nova Scotia	Canada	Doctors
College of Registered Nurses of Nova Scotia	Nova Scotia	Canada	Nurses
Registered Nurses Association of NWT & Nunavut	Nunavut	Canada	Nurses
College of Midwives of Ontario	Ontario	Canada	Midwives
College of Physicians & Surgeons of Ontario	Ontario	Canada	Doctors
PEI Pharmacy Board	Prince Edward Island	Canada	Pharmacists
College des medecines du Quebec	Qubec	Canada	Doctors
Ordre des infirmieres et infirmiers du Quebec	Quebec	Canada	Nurses
Ordre des Sage-femmes du Quebec	Quebec	Canada	Midwives
Ordre des Pharmaciens du Quebec	Quebec	Canada	Pharmacists
College of Physicians & Surgeons - Saskatchewan	Saskatchewan	Canada	Doctors
Government of Yukon	Yukon Territory	Canada	Nurses, Doctors & Pharmacists
The National Board of Health, Denmark	Denmark	Denmark	Midwives, Nurses & Doctors
Danish Medicines Agency	Denmark	Denmark	Pharmacists
Conseil National de L'Ordre des Sages-Femmes	France	France	Midwives
Ordre National des Pharmaciens - France	France	France	Pharmacists
State Office of Health & Social Affairs Berlin	Germany	Germany	All Four
Ministry of Health Kenya	Kenya	Kenya	Midwives & Nurses
Pharmacy Council of New Zealand	New Zealand	New Zealand	Pharmacist
Medical Council of New Zealand	New Zealand	New Zealand	Doctors
Nursing Council of New Zealand	New Zealand	New Zealand	Midwives
Ordem Dos Enfermeiros	Portugal	Portugal	Midwives & Nurses
Ordem dos Medicos	Portugal	Portugal	Doctors & Pharmacists
Singapore Medical Council	Singapore	Singapore	Doctors
The South African Pharmacy Council	South Africa	South Africa	Pharmacists
Central Agency for Professions in Health Care, Ministry of Health, Welfare & Sport	The Netherlands	The Netherlands	All four
Virgin Islands Board of Nurse Licensure	U. S. Virgin Islands	U.S Virgin Islands	Midwives & Nurses
Nursing & Midwifery Council (NMC) United Kingdom	United Kingdom	United Kingdom	Midwives
Alabama Board of Nursing	Alabama	USA	Midwives & Nurses
Alaska State Board of Pharmacy	Alaska	USA	Pharmacists
Arizona State Board of Nursing	Arizona	USA	Midwives & Nurses
Arkansas State Board of Nursing	Arkansas	USA	Midwives & Nurses
Arkansas Department of Health (ADH)	Arkansas	USA	Midwives (Direct Entry)
Medical Board of California	California	USA	Midwives & Doctors

Organization	Jurisdiction	Country	Profession reporting on
Colorado (Direct Entry) Midwifery Registration	Colorado	USA	Midwives (Direct Entry)
Colorado Midwifery Registration	Colorado	USA	Midwives
Colorado Board of Medical Examiners	Colorado	USA	Doctors
Florida Board of Nursing	Florida	USA	Midwives & Nurses
Georgia Board of Nursing	Georgia	USA	Nurses
Idaho Board of Pharmacy	Idaho	USA	Pharmacists
Idaho Board of Nursing	Idaho	USA	Midwives & Nurses
Illinois Division of Professional Regulation	Illinois	USA	Pharmacists
Iowa Board of Medical Examiners	Iowa	USA	Doctors
Kansas State Board of Nursing	Kansas	USA	Midwives & Nurses
Kansas Board of Pharmacy	Kansas	USA	Pharmacists
Louisiana State Board of Medical Examiners	Louisiana	USA	Doctors
Louisiana State Board of Medical Examiners	Louisiana	USA	Midwives (Direct Entry)
Maine Board of Licensure in Medicine	Maine	USA	Doctors
Maine Board of Pharmacy	Maine	USA	Pharmacists
Maryland Board of Pharmacy	Maryland	USA	Pharmacists
Massachusetts Board of Registration in Nursing	Massachusetts	USA	Nurses
Missouri State Board of Nursing	Missouri	USA	Midwives & Nurses
Nevada Board of Pharmacy	Nevada	USA	Pharmacists
Nevada State Board of Nursing	Nevada	USA	Nurses
New Hampshire Board of Nursing	New Hampshire	USA	Midwives & Nurses
New Jersey Board of Nursing	New Jersey	USA	Nurses
New Mexico Medical Board	New Mexico	USA	Doctors
New York State Board of Nursing	New York	USA	Nurses
North Carolina Medical Board	North Carolina	USA	Doctors
North Carolina Board of Nursing	North Carolina	USA	Midwives & Nurses
North Carolina Board of Pharmacy	North Carolina	USA	Pharmacists
Ohio Board of Nursing	Ohio	USA	Midwives & Nurses
Oklahoma State Board-Medical Licensure & Supervision	Oklahoma	USA	Doctors
Oregon Board of Medical Examiners	Oregon	USA	Doctors
Health Licensing Office Board of Direct Entry Midwives	Oregon	USA	Midwives (Direct Entry)
Pennsylvania Bureau of Professional & Occupational Affairs	Pennsylvania	USA	Pharmacists
South Dakota Board of Nursing	South Dakota	USA	Midwives & Nurses
Tennessee Board of Pharmacy	Tennessee	USA	Pharmacists
Texas Department of State Health Services; Texas (Direct Entry) Midwifery Board	Texas	USA	Midwives (Direct Entry)

Organization	Jurisdiction	Country	Profession reporting on
D.C. Board of Medicine	The District of Columbia (Washington)	USA	Doctors
Vermont Secretary of State's Office, Office of Professional Regulation, Direct Entry Midwives	Vermont	USA	Midwives (Direct Entry)
Vermont Board of Nursing	Vermont	USA	Nurses
Virginia Department of Health Professions	Virginia	USA	Midwives & Nurses
Virginia Department of Health Professions	Virginia	USA	Doctors
Virginia Department of Health Professions	Virginia	USA	Pharmacists
Washington State Department of Health	Washington State	USA	Midwives & Nurses
Washington State Medical Quality Assurance Commission	Washington State	USA	Doctors
State of Washington Dept. of Health Midwifery Program	Washington State	USA	Midwives (Direct Entry)
Wisconsin Department of Regulation & Licensing	Wisconsin	USA	All four
Wyoming Board of Medicine	Wyoming	USA	Doctors
Wyoming Board of Nursing	Wyoming	USA	Midwives & Nurses
Zimbabwe Medical & Dental Practitioners Council	Zimbabwe	Zimbabwe	Doctors