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ORIGINAL RESEARCH ARTICLE

Selection Criteria for International Medical Graduates in Rural Saskatchewan:

A Survey-Based Investigation of Faculty Assessors and Rural Physician Leaders

Abstract

Background: International Medical Graduates (IMGs) are essential to the rural physician workforce in Canada. However, selection criteria for IMGs into family medicine practice ready assessment (PRA) programs, particularly "currency of practice," is inconsistent in both duration and scope. This study explored the perspectives of SIPPA faculty assessors and rural physician leaders in Saskatchewan to inform more aligned and inclusive selection criteria.

Methods: A cross-sectional survey was administered to 104 SIPPA assessors and Saskatchewan Health Authority (SHA) rural physician leaders in June 2024. The survey assessed acceptable durations of recent clinical activity, views on alternative clinical experiences (eg: clinical assistant, GP-specialist, postgraduate training, telemedicine), and selection priorities. Quantitative data were analyzed using descriptive statistics and comparative tests.

Results: Sixty-three responses were received (61% response rate). Respondents generally supported increasing recent clinical practice requirements as time out of enduring practice increased. For IMGs out of practice >5 years, 58% recommended 12–24 months of recent clinical experience. SHA leaders were more likely than SIPPA assessors to require this duration (85.0% vs. 51.6%, $p = 0.05$). Most participants supported recognizing licensed clinical assistant roles (71.9%), postgraduate training (87.5%), and GP-specialist roles (79.7%) as valid currency. Only 21.9% endorsed telemedicine experience.

Conclusions: Stakeholders support increased recent clinical activity and inclusive selection criteria for IMGs. Clarifying and aligning selection criteria for family medicine PRA programs may enhance fairness, consistency, and effectiveness of IMG assessment.

Background

International Medical Graduates (IMGs) play a vital role in meeting rural and remote physician workforce needs in Canada.[1] In Saskatchewan, IMGs constitute a significant proportion of the rural family medicine workforce, especially in communities with persistent recruitment and retention challenges.[2] To support safe and equitable licensure, Practice Ready Assessment (PRA) programs in Canada conduct structured competency assessments of internationally trained physicians (ITPs) on behalf of provincial Medical Regulatory Authorities (MRAs), who ultimately make licensure decisions. [3,4] The Saskatchewan International Physician Practice Assessment (SIPPA) is one such PRA program focused on family medicine, designed to evaluate whether IMGs and ITPs are ready to enter independent practice.[3,4] Since its launch in 2011, SIPPA has assessed over 600 family physicians for licensure, the majority of whom have been placed in rural or northern communities across the province.[2,4] While all Canadian PRA programs share a common mandate to assess IMG/ITP competence through standardized tools and supervised clinical field assessment, each province defines its eligibility and program structure independently.[5,6] In Saskatchewan, SIPPA includes two main components: (1) a preentry selection phase and (2) a 12-week Clinical Field Assessment (CFA), during which candidates are assessed in a rural or regional family medicine setting across core competencies, communication, clinical reasoning, and adaptation to the Canadian healthcare system.[7]

To be eligible for SIPPA,[8] candidates must meet a set of mandatory medical regulatory and SIPPA program requirements including: a recognized medical degree, English language proficiency, successful completion of at least, one year post-graduate training, successful completion of the Medical Council of Canada Qualifying Examination Part 1 (MCCQE1), the National Assessment Collaboration (NAC OSCE), and the MCC Therapeutics Decision-Making (TDM) exam.[8,9] Beyond exam performance, the selection committee assess "currency of practice," which refers to the recency, continuity, and scope of recent clinical experience, typically within the past three years.[6,7] This includes evaluation of gaps in practice and consideration of alternative roles (eg: licensed Clinical Assistant positions). Greater scrutiny is applied for candidates out of "enduring practice," defined as ≥12 months of continuous, independent clinical work.[6,10,11]

Despite SIPPA's established role in rural family physician competency assessment, there remains limited research on how key eligibility criteria (particularly "currency of practice") are interpreted and applied by those responsible for candidate selection and supervision. Faculty assessors from the University of Saskatchewan are involved in the 12-week CFA

assessment, while physician leaders within the Saskatchewan Health Authority (SHA) oversee and support IMGs during their clinical practice. We thought their insights would be critical to informing equitable and evidence-informed policies for IMG selection. Hence, we conducted a provincial survey of SIPPA assessors and SHA rural physician leaders to examine their perspectives on what constitutes sufficient currency of practice for IMGs, and how alternative clinical experiences should be evaluated. We also explored open-ended responses to identify additional themes related to IMG readiness for rural family practice. The findings from this study would aim to inform and refine policies and processes for IMG selection within SIPPA and other PRA programs across Canada.

Methods

We employed a cross-sectional survey design to explore the perspectives of SIPPA faculty assessors and Saskatchewan Health Authority (SHA) rural physician leaders on the selection of International Medical Graduates (IMGs), particularly in relation to currency of practice.

Participants and Setting

The survey was distributed to 104 individuals involved in IMG assessment and/or selection in Saskatchewan, including SIPPA assessors and rural SHA leadership (eg: Area Chiefs of Staff and Family Medicine Department/Division Leads).

Survey Instrument

A self-administered questionnaire was developed to assess respondents' views on selection criteria for IMGs who have been out of "enduring practice" (defined as ≥12 months of continuous, full-time clinical practice). The survey asked participants to indicate what duration of "currency of practice" (defined as recent clinical practice of <12 months, including licensed clinical assistant roles, recent postgraduate training, or practice outside Canada) they deemed appropriate based on time out of enduring practice: <3 years, 3–5 years, and >5 years. Additional items explored whether various forms of clinical experience (eg: licensed clinical assistant/associate, GP-specialist, postgraduate training, telemedicine) should be credited toward currency of practice. Open-text fields invited qualitative feedback on SIPPA selection processes. The instrument was piloted with five reviewers and revised for clarity and relevance. See Supplementary File A at the end of this article for the survey sample.

Data Collection

Surveys were distributed online via REDCap[12] on June 18, 2024, following a modified Dillman method,[13] which included an advance notice email, initial survey invitation, and two follow-up reminders spaced two weeks apart, to maximize response rates and minimize bias. Participation was voluntary and anonymous. Implied consent was obtained through survey completion.

Ethical Considerations

Ethics approval was granted by the University of Saskatchewan Behavioral Research Ethics Board (Beh-REB #4680).

Data Analysis

Descriptive statistics (frequencies and percentages) were used to summarize categorical data. Group comparisons (SIPPA vs SHA respondents) were conducted using Chi-square, Fisher's Exact tests or Mann-Whitney U tests as appropriate. For subgroup comparisons between SIPPA assessors and SHA leaders, we ndependence across groups. However, these individuals were retained in the overall descriptive analysis and the qualitative thematic analysis. Open-ended responses were analyzed thematically using inductive content-thematic analysis to quantify and identify emerging themes.

Results

Participant Characteristics

Of the 104 invited participants, 63 completed the survey (response rate = 61%). Most excluded participants who identified as serving in both roles to maintain statistical respondents were male (78.1%) and over the age of 40 (87.5%). Half had been in practice for more than 10 years, and nearly half practiced in rural or remote locations (48.4%). Participants included 31 SIPPA assessors (48.4%), 20 SHA physician leaders (31.3%), and 12 (18.8%), served in both roles (Table 1).

TABLE 1: Demographic characteristics of survey participants (*n*=63)

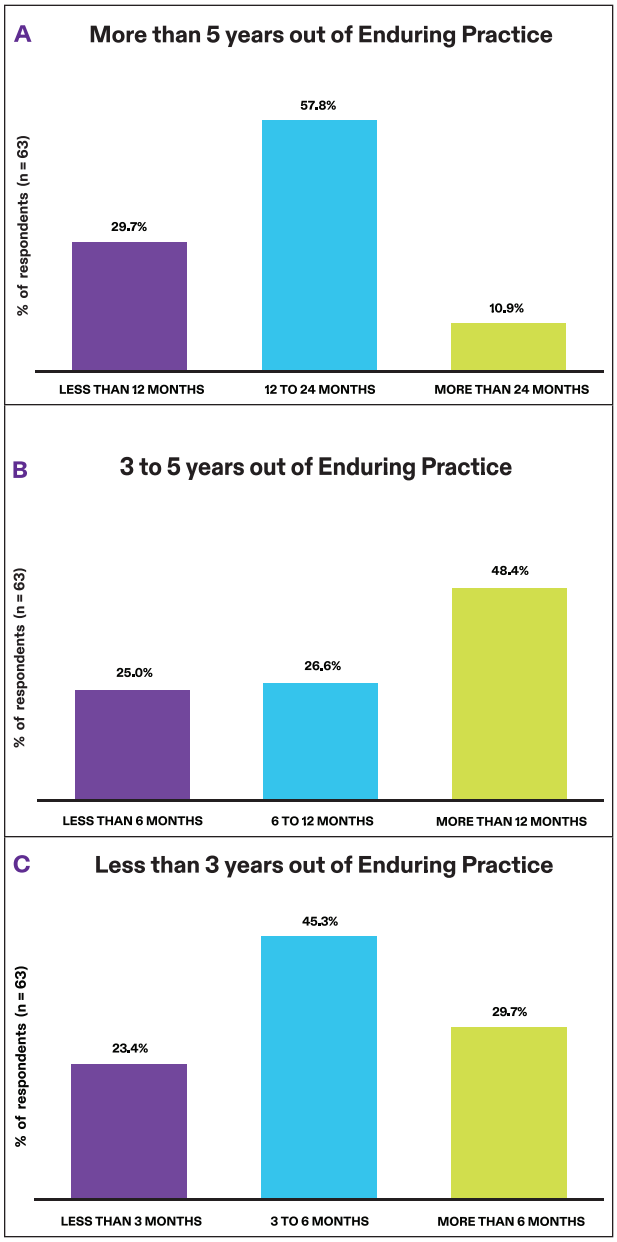
Variable	Frequency (%)
Demographics	
Sex	
Male	50 (78.1)
Female	13 (20.3)
Age Category	
Under 30 years	0 (0.0)
30-39 years	8 (12.5)
40-49 years	24 (37.5)
50-59 years	23 (35.9)
60 years and over	9 (14.1)
Current Practice Location	
Rural/Remote	31 (48.4)
Regional	20 (31.3)
Urban	12 (18.8)
Number of Years of Practice	
Less than 1 year	0 (0.0)
1-5 years	7 (10.9)
5-10 years	24 (37.5)
More than 10 years	32 (50.0)
Role	
SHA Leader	20 (31.3)
SIPPA Assessor	31 (48.4)
Both	12 (18.8)
SHA Leadership Roles only*	
ACOS	4 (6.3)
Area Department Lead FM	7 (10.9)
Area Division Lead FM	14 (21.9)
Other	4 (6.3)

*Respondents could select more than one SHA leadership role; therefore, frequencies are not mutually exclusive and do not sum to the total sample.

Currency of Practice Preferences

Figure 1 illustrates participants' views on the minimum recent clinical experience ("currency of practice") required for IMG candidates based on the duration of their time out of enduring practice. For candidates who had been out of practice for less than three years, nearly half (45.3%) of respondents believed that three to six months of recent clinical work should be required. For those with a gap of three to five years, 48.4% favored requiring 6-12 months of practice. When the gap extended beyond five years, the majority (57.8%) recommended at least twelve to twenty-four months of recent clinical experience before selection into the SIPPA program.

FIGURE 1: Currency of Practice Based on Time Out of Enduring Practice



Legend: Respondent views on the minimum duration of recent clinical experience ("currency of practice") required for SIPPA eligibility, stratified by time out of enduring practice. Percentages represent the proportion of total survey respondents (*n* = 63).

Recognition of Alternative Clinical Experiences

Participants largely endorsed the inclusion of non-traditional clinical experiences as valid forms of currency of practice. Most respondents supported rec-

ognizing clinical work as a Licensed Clinical Associate or Assistant in generalist roles (71.9%), as well as additional postgraduate training in family medicine or generalist clinical rotations (87.5%). A substantial majority (79.7%) also agreed that GP-specialist practices (such as GP-anesthesia, GP-surgery, or GP-obstetrics) should be considered relevant to SIPPA readiness. In contrast, only a minority (21.9%) supported crediting telemedicine experience as equivalent clinical currency. See Table 2.

TABLE 2: Perspectives on IMG Selection Criteria for SIPPA: Overall and Subgroup Comparisons Between SHA Leaders and SIPPA Assessors

Survey Item	Overall (*n*=63)	Subgroup comparisons (*n*=51)		
	All (*n*=63)	SHA (*n*=20)	SIPPA (*n*=31)	*p*-value
a) If a physician has been out of ENDURING PRACTICE for less than three years, how much CURRENCY OF PRACTICE should that physician attain in the three years prior to selection to be considered for SIPPA?				
- Less than 3 months	15 (23.4%)	3 (15.0%)	10 (32.3%)	0.383
- 3–6 months	29 (45.3%)	10 (50.0%)	12 (38.7%)	
- More than 6 months	19 (29.7%)	7 (35.0%)	9 (29.0%)	
b) If a physician has been out of ENDURING PRACTICE for three to five years, how much CURRENCY OF PRACTICE should that physician attain in the three years prior to selection to be considered for SIPPA?				
- Less than 6 months	16 (25.0%)	3 (15.0%)	10 (32.3%)	0.382
- 6–12 months	31 (48.4%)	11 (55.0%)	14 (45.2%)	
- More than 12 months	16 (25.0%)	6 (30.0%)	7 (22.6%)	
c) If a physician has been out of ENDURING PRACTICE for more than five years, how much CURRENCY OF PRACTICE should that physician attain in the three years prior to selection to be considered for SIPPA?				
- Less than 12 months	19 (29.7%)	2 (10.0%)	11 (35.5%)	0.05*
- 12–24 months	37 (57.8%)	17 (85.0%)	16 (51.6%)	
- More than 24 months	7 (10.9%)	1 (5.0%)	4 (12.9%)	
d) Should clinical practice as a Licensed Clinical Associate/Assistant in a generalist role (ie: hospitalist or Primary Health Care) be credited as currency of practice?				
- Yes	46 (71.9%)	12 (60.0%)	24 (77.4%)	0.240
- No	13 (20.3%)	5 (25.0%)	6 (19.4%)	
- Other	4 (6.8%)	3 (15.0%)	1 (3.2%)	
e) Should additional post-graduate training in Family Medicine or rotations with a generalist scope of practice be credited as currency of practice?				
- Yes	56 (87.5%)	16 (80.0%)	29 (93.5%)	0.05*
- No	4 (6.3%)	1 (5.0%)	2 (6.5%)	
- Other	3 (4.7%)	3 (15.0%)	0 (0.0%)	
f) Should telemedicine be considered/credited for CURRENCY OF PRACTICE?				
- Yes	14 (21.9%)	2 (10.0%)	8 (25.8%)	0.155
- No	43 (67.2%)	15 (75.0%)	22 (71.0%)	
- Other	4 (6.8%)	3 (15.0%)	1 (3.2%)	
g) Should physicians who have a GP-Specialist practice be considered for SIPPA (ie: GP Surgeon, GP-Anesthesia, GP-Pediatrics, GP-O&G, etc.)?				
- Yes	51 (79.7%)	13 (65.0%)	27 (87.1%)	0.118
- No	6 (9.4%)	2 (10.0%)	3 (9.7%)	
- Other	6 (9.4%)	4 (20.0%)	1 (3.2%)	

**p*-value is significant for level of significance <5%.

Subgroup Comparisons: SIPPA vs. SHA Respondents

There was strong agreement across both SIPPA assessors and SHA leaders on the importance of recent clinical experience and the value of diverse practice pathways. Respondents from both groups generally endorsed crediting roles such as clinical assistant, GP-specialist, and postgraduate training as valid forms of currency of practice, and few supported crediting telemedicine experience.

Only two statistically significant differences emerged. For IMGs who had been out of enduring practice for more than five years, SHA leaders were more likely than SIPPA assessors to recommend requiring 12–24 months of recent clinical experience (85.0% vs. 51.6%; $p = 0.05$). In contrast, SIPPA assessors were more likely to recognize postgraduate family medicine training as valid currency (93.5% vs. 80.0%; $p = 0.05$). These differences may reflect the different vantage points of those involved in pre-admission selection versus those supervising clinical readiness in practice, but the overall findings point to broad concordance in selection priorities across both groups. Notably, there was strong concordance between SIPPA assessors and SHA leaders in endorsing the recognition of alternative clinical experiences. Both groups broadly supported crediting clinical assistant/associate roles and GP-specialist practices (such as GP-anesthesia, GP-obstetrics, or GP-surgery) as valid components of currency of practice. This alignment highlights a shared willingness to move beyond rigid eligibility thresholds and consider more inclusive, competency-informed pathways to practice readiness. See Table 2.

Qualitative Findings from Open-Text Responses

Open-text responses to the question "Please share any additional thoughts you have regarding selection criteria for SIPPA" revealed four key themes. These insights expand on the structured survey findings by emphasizing relational, contextual, and system-level factors considered critical for IMG readiness in rural practice.

Theme 1: Emergency room (ER) experience as essential for rural readiness

ER exposure was noted as particularly valuable for practice in rural contexts, where physicians often work in settings with limited specialist backup. One SHA leader stated:

> *"Many SIPPA candidates have limited acute care experience... Expectation of competency in emergency medicine also seems rather low" (P22-SHA physician Leader).*

Another advised that:

> *"Emergency room experience should be a requirement for rural placement" (P3-Both SIPPA assessor and SHA physician leader).*

Another SHA leader added requiring ACLS, PALS, and ATLS certifications:

> *"ATLS/PALS/ACLS training should be a prerequisite or done within 6 months of starting SIPPA" (P10- SHA physician Leader).*

Theme 2: Structured supervision, mentorship, and clinical training

SIPPA is the only PRA program with structured supervision and mentorship extending beyond the PRA period into early independent practice. Accordingly, participants emphasized the importance of formal mentorship or supervision supports following SIPPA entry to sustain integration and readiness.

> *"Any IMG who is deemed qualified should be made to have supervision under a licensed practitioner to increase intake to the program and facilitate the need to meet the shortfalls of family doctors in Canada" (P1- Both SIPPA assessor and SHA physician leader).*

Theme 3: Language proficiency and communication of IMGs

A few participants stressed that language skills must go beyond conversational fluency (both on expressive and receptive communication) to include comfort with medical terminology and patient-centered communication.

> *"Language proficiency specifically relating to the practice of medicine should be necessary requirement for selection" was a recommended focus for selection criteria (P2-SIPPA assessor).*

Theme 4: Rural ties and community familiarity as predictors of retention

Many participants emphasized the importance of selecting candidates with prior ties to Saskatchewan or rural communities as a strategy for improving long-term retention. One SIPPA assessor wrote

> *"Selection should also look at the possibility of retention. For example, consider prioritizing those who already have ties to Saskatchewan and place them in those communities where they are more likely to stay" (P2-SIPPA Assessor).*

Another participant noted that

> *"Saskatchewan-based IMGs, or ties to SK, should be prioritized like the Alberta/Manitoba programs" (P21-SHA physician Leader).*

Discussion

Our study provides one of the first empirical assessments of how clinical readiness (particularly currency of practice) is interpreted by those involved in selecting IMGs for Saskatchewan's SIPPA program. Across SIPPA assessors and Saskatchewan Health Authority (SHA) rural physician leaders, there was clear consensus that physicians who have been out of practice for longer durations should demonstrate more months of recent clinical experience. This agreement offers a potential foundation for standardizing regulatory expectations across roles involved in IMG evaluation and supervision.[14-16]

Beyond recency of practice, strong concordance emerged around the recognition of alternative clinical experiences as valid forms of currency. Both SIPPA and SHA respondents endorsed post-graduate family medicine training, licensed Clinical Assistant/Associate roles, and GP-specialist practice (eg: GP-anesthesia, GP-obstetrics, GP-surgery) as acceptable indicators of readiness. These findings suggest an important regulatory shift toward more inclusive, competency-informed criteria — acknowledging diverse pathways through which IMGs acquire relevant clinical experience.

While statistically significant differences were observed in two areas (ie: acceptable recency for IMGs out of practice >5 years and crediting post-graduate FM training) overall alignment across stakeholder groups was far more prominent. This shared perspective provides an actionable base for regulatory bodies and practice-readiness programs to define clearer, harmonized standards for selection. Despite telemedicine's increasing role in rural service delivery, it received limited support as a valid contributor to clinical currency from our survey. This result may reflect perceptions that telemedicine lacks the hands-on experience necessary for rural readiness, particularly in high-acuity or procedural contexts.[17,18] It may also signal uncertainty about how to assess competence in virtual care environments.[19,20] Future research could explore these given that virtual care has been gaining more traction in rural primary care.

Our study provides one of the first empirical assessments of how clinical readiness (particularly currency of practice) is interpreted by those involved in selecting IMGs for Saskatchewan's SIPPA program.

In addition to the survey data, open-text responses revealed recurring themes that expand our understanding of readiness. Participants emphasized the importance of emergency department experience, structured post-selection mentorship, language proficiency and rural ties in supporting IMG success. These relational and contextual considerations extend beyond technical competence and underscore the importance of community embeddedness and system navigation support in rural physician retention and performance.[21,22] Interestingly, several comments also recommended measures or safeguards that are already integrated into the SIPPA process, including credential verification, ER readiness, and formal supervision. This suggests a possible disconnect or lack of visibility into the rigour of our existing selection and assessment procedures. As such, future work might explore how transparency, communication, and stakeholder orientation around SIPPA's evolving processes could be enhanced to foster shared understanding and strengthen trust in the program's quality assurance mechanisms.

Taken together, these insights reinforce the need for PRA programs and regulatory frameworks to incorporate not only clinical proficiency but also integration supports, rural contextualization, and continued system engagement.

Implications

Our study provides key insights to inform the regulatory alignment of practice-readiness programs like SIPPA. First, there was strong agreement that physicians with longer gaps from enduring practice require increased months of recent clinical experience. Second, assessors and leaders aligned on the importance of recognizing diverse forms of clinical practice (including postgraduate training, clinical assistant/associate roles, and GP-specialist work) as valid contributors to currency of practice. These findings provide a clear rationale for regulators to formalize expectations around both recency and scope of clinical experience, using flexible yet transparent criteria.

In addition, the value placed on contextual factors such as rural roots, ER experience, and structured mentorship highlights the need to embed retention-oriented indicators into the selection process. Collectively, our findings support the development of harmonized, inclusive, and community-sensitive frameworks for IMG selection into practice readiness programs across Canada.

Limitations

Our study has several limitations. First, although the response rate was strong (61%), findings are grounded in Saskatchewan's SIPPA program and may not fully generalize to other provincial PRA programs that operate under different workforce pressures, assessment models, or regulatory frameworks. Second, the survey relied on self-reported perspectives, which may be influenced by personal biases, professional roles, or institutional contexts. Third, while we conducted subgroup analyses to explore role-based differences, the modest sample size limited statistical power to detect small or nuanced effects. Additionally, our study focused on stakeholder perceptions and did not assess how these selection views correlate with actual outcomes; such as candidate performance during the CFA, remediation needs, or post-licensure practice quality. This represents an important area for future research inquiry. Finally, although telemedicine is playing an increasingly important role in rural healthcare delivery, it was rarely endorsed as a valid contributor to clinical currency. Further qualitative inquiry may help clarify stakeholder reservations about virtual care experience in the context of practice-readiness assessment.

Conclusions

Our study revealed largely concordant perspectives of SIPPA faculty and rural SHA leaders on criteria for selecting IMG physicians into Saskatchewan's rural family medicine practice ready assessment program. There was broad support for increased recent clinical experience for physicians with longer gaps in practice, as well as an openness to recognize diverse clinical experiences as currency of practice. These findings can inform a more evidence-informed selection framework that strengthen the consistency, and effectiveness of IMG assessment.

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SUPPLEMENTARY FILE A: Online survey

Title: Assessment of IMG Selection Criteria

Thank you for participating in this survey. This survey should take 4 minutes, depending on how you answer. Your insights as faculty assessors and rural physician leaders (ACOS, FM ADLs) are invaluable in shaping the selection criteria for International Medical Graduates (IMGs) participating in the Saskatchewan International Physician Practice Assessment (SIPPA) program. Your feedback will help enhance the selection process and contribute to the quality of healthcare delivery in rural Saskatchewan.

Section 1: Demographics

1. **Sex:** ☐ Male ☐ Female ☐ Other
2. **Age:** ☐ Under 30 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60 or over
3. **Current Practice Location:** ☐ Rural/Remote ☐ Regional ☐ Urban
4. **Number of Years of Practice (in Canada):** ☐ Less than 1 year ☐ 1 to 5 years ☐ 5 to 10 years ☐ Above 10 years
5. **Are you a** ☐ SIPPA Assessor ☐ SHA leader (with break-out options: ☐ ACOS, ☐ Area Dept Lead FM, ☐ Area Division Lead FM ☐ Other (specify)_____) (check all that apply)
6. **Number of Years in Current Role:** _____

Section 2: Perspectives on Selection Criteria

Definitions:

* ENDURING PRACTICE refers to continuous full-time clinical practice of 12 months or more.

** CURRENCY OF PRACTICE refers to recent clinical practice of less than 12 months. It may include clinical practice outside of Canada as a fully licensed physician, as a licensed Clinical Assistant/Associate in Canada, or recent post-graduate training.

7. If a physician has been out of ENDURING PRACTICE* for less than three years, how much CURRENCY OF PRACTICE** should that physician have in the three years prior to selection to be considered for SIPPA?
   a. Less than 3 months
   b. 3-6 months
   c. More than 6 months
8. If a physician has been out of ENDURING PRACTICE* for three to five years, how much CURRENCY OF PRACTICE** should that physician have in the three years prior to selection to be considered for SIPPA?
   a. Less than 6 months
   b. 6-12 months
   c. More than 12 months
9. If a physician has been out of ENDURING PRACTICE* for more than five years, how much CURRENCY OF PRACTICE** should that physician have in the three years prior to selection to be considered for SIPPA?
   a. Less than 12 months
   b. 12-24 months
   c. More than 24 months

Other Training:

10. Should training as Licensed Clinical Associate/Assistant in a generalist role (ie: hospitalist or Primary Health Care be credited as CURRENCY OF PRACTICE?
    ☐ Yes ☐ No ☐ Other. If other, please describe:
    _____
11. Should additional post-graduate training in Family Medicine or with a generalist scope of practice be credited as CURRENCY OF PRACTICE?
    ☐ Yes ☐ No ☐ Other. If other, please describe:
    _____
12. Should physicians who have a GP-Specialist practice be considered for SIPPA (i.e., GP-Surgeon, GP-Anesthesia, GP-Pediatrics, GP-O&G, etc.) for CURRENCY OF PRACTICE?
    ☐ Yes ☐ No ☐ Other. If other, please describe:
    _____
13. Should telemedicine be considered/credited for CURRENCY OF PRACTICE?
    ☐ Yes ☐ No ☐ Other. If other, please describe:
    _____
14. Please share any additional thoughts you have regarding selection criteria for SIPPA: _____
    _____

Thank you for completing this survey. Your feedback is greatly appreciated. Please click 'Submit' to submit your response.