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Chair

Mrs. Joy Smith

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● (0905)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good morning, everybody.

I notice that we're a little past nine o'clock, so we definitely should start now.

Pursuant to Standing Order 108(2), we are doing our study on health human resources.

Today I'm very pleased that we have, from the Alberta International Medical Graduates Association, Ali Varastehpour, vice-president, and Chander Hariramani, treasurer. It's very nice to have you here. Welcome.

From the Canadian Resident Matching Service we have Jim Boone, general manager and chief executive officer. And from the Federation of Medical Regulatory Authorities of Canada we have Fleur-Ange Lefebvre, executive director and chief executive officer of that association.

We also have with us, from J.A. Hildes Northern Medical Unit, Dr. Bruce Martin, from the faculty of medicine, University of Manitoba. That's one I'm very familiar with, Dr. Martin. I hear quite a bit about you, because my own daughter wants to go into medicine.

And from the Medical Council of Canada we have Dr. Ian Bowmer, executive director and chief executive officer. We are so pleased to have you here.

We're going to have five-minute presentations from each of the organizations, and following that we'll go into our questions and answers.

We will begin with the Alberta International Medical Graduates Association, Mr. Ali Varastehpour.

Dr. Ali Varastehpour (Vice-President, Edmonton, Alberta International Medical Graduates Association): We would like to begin by expressing our sincere gratitude to the members of the Standing Committee on Health for inviting us to Ottawa today.

The issues related to skilful immigrants coming to Canada in general, and physicians in particular, are evolving from a domestic issue into an international one. I would like to draw your kind attention to the report recently released by the UN expert on minority affairs. I have a copy of this report here for members of the committee to review.

I would like to read item number seven directly from this report, as it is particularly relevant to our present discussion. I will leave a copy of this with the clerk later on.

Item number seven, issued by Gay McDougall, says:

> There is a deep level of frustration among minority communities that highly qualified and skilled workers have been encouraged to migrate to Canada, only to find on their arrival that their qualifications are not recognized at the provincial level. They are unable to gain employment in their former professions despite critical shortages, including of doctors and nurses in some regions. I was told of numerous cases of professionals who described being recruited when practising their professions in their home countries but have faced lengthy, expensive, and unexpected hurdles to satisfy the credentialing requirements in the various provinces in Canada. Meanwhile they are forced to resort to take on low skilled, low waged, precarious employment for years. For some, the difficulties experienced have led to their living in conditions of hardship and poverty. The cliché of 'doctors driving taxi cabs' resonates as reality for many minority professionals in Canada.

Right now, regulatory bodies apply different rules to different physicians. While their discretionary power is important, it is equally important to note that their inconsistent actions are costing Canada on the international stage, and are affecting our goals and aspirations.

Presently the Medical Council of Canada administers three exams: evaluating exam, or EE, qualifying exam 1, and qualifying exam 2. The first one, the evaluating exam, is applied at an increasing cost to foreign graduates only. We speculate that this exam is similar to the old ESFMG, in that it was composed of questions that normal Canadian students find hard to answer. It serves as a source of income to the MCC and a hurdle for foreign graduates. Widespread objections in the United States were partly responsible when they switched to a new unified exam for both American and foreign grads. They switched in the past few years.

So far, we have been successful in passing these exams, mostly through our own sweat and blood and effort. This does not mean we reached the level set by MCC, however. We have indeed surpassed it. MCC favours Canadian students by repeating question items under exams. It is a well-known fact that Canadian medical schools collect and indeed answer these questions and circulate them amongst their own. Thus, when we pass the exam, we feel a great sense of pleasure competing, and beating Canadian students in their own home field.

We believe there are huge deficiencies in the undergraduate Canadian medical education system, but we won't spend any time on that, as it is not the focus of our discussion today.

Parallel to the above-mentioned exams and their associated costs, you might be surprised to know that post-graduate physicians come to this country every day to pursue their graduate medical training, based only on passing the evaluating examination in their home country. Program directors fill their spots by recruiting these students, who are willing to work for free. In turn, department chairs require them to take no more exams but the evaluating exam and pass it at any score and any number of times.

Yes, ladies and gentlemen, money talks here, and people have been buying their way into the Canadian medical system openly and legally for a long, long time.

In my humble opinion, this practice is not only unethical, it is purely illegal. In fact, if we had sufficient funds or faith in the Canadian justice system, we would have challenged the regulatory bodies and all academic hospitals in this country for monetary and emotional damages inflicted upon so many families.

● (0910)

Honourable members of the House, I'm not here to ask for preferential treatment; I'm simply asking that the same rules are applied to us. This requires funding of the residency programs through legislative efforts.

This year over 300 positions were left unfilled all across Canada. I suspect that there would have been a lot more positions available today if so-called visa students were kept out of the system.

I'm not aware if any other country has ever pursued this shameful model. No one can deny that Canada is training more doctors for other countries than it does for its own.

The dilemma surrounding postgraduate medical study does not stop here. If you have a cursory look at the website of the University of Alberta Hospital, you would find academic...[*Inaudible—Editor*]...with no real college designation, some with only an evaluating exam under their belts, and some even have doubtful residency training even in their own home countries. Yet they have been licensed to practise medicine in Alberta.

Honourable members of the House, I am here to tell you that Canada has a pool of qualified physicians willing to work all over Canada. We are proud to see ourselves as Canadians in a few years. Our Canadian dream has been freedom, democracy, and achieving excellence in our profession. Unfortunately, regulatory bodies are acting beyond their duties and functioning more like gatekeepers for class and prestige, and this must stop. We will continue to struggle until race, religion, and accent play no role in getting medical licensure.

We are puzzled as to why Immigration Canada brings to this country over 200,000 people a year when doctors cannot do doctoring, and carpenters, plumbers, and gardeners cannot follow their passions in Canada. Perhaps Immigration Canada should be converted to Colonization Canada, and they can use modern techniques of biology to clone human beings and place them wherever they want.

Finally, I would like to talk about sporadic good efforts in Alberta that can be extended to all over Canada. Alberta has the M-CA program, the mdical communication assessment program, which trains physicians in language skills and oral exams. Expansion of programs like M-CAP into a bridging program that would include clinical training would benefit us and Canada enormously. Again, it requires your political will and effort.

Wider introduction of limited registration would be another area where experienced, practice-ready physicians would be able to enter the workforce.

I thank you again for your attention. Please do not hesitate to contact me if I can be of any service to this committee. Thank you very much for your attention.

The Chair: Thank you very much.

Now we will go to our next presenter, who is from the Canadian Resident Matching Service. Jim Boone, please.

Mr. Jim Boone (General Manager, Canadian Resident Matching Service): Thank you.

Just one point of clarification: I'm not the CEO of CaRMS; I'm the general manager of CaRMS. I'm actually here pinch-hitting for Sandra Banner, who sends her regrets and was unfortunately unable to attend this meeting.

CaRMS is the gateway into post-graduate medical education in Canada. We hear on a daily basis the frustrations of international medical graduates and their concerns because we're an independent organization that sits on the fence between faculty and applicants for post-graduate training. So we do hear frustration, as Ali has expressed, from the thousands of IMGs across this land.

We've been matching eligible applicants to post-graduate medical training since 1970. This year is our fortieth anniversary. CaRMS has been serving the needs of IMGs and has been part of the system and in the matching process since day one, since 1970. The goal of our online electronic application service and matching service is to be completely transparent and accessible as a process. It's often misunderstood that CaRMS sets policies on recruitment. It's the Association of Faculties of Medicine of Canada, or AFMC, that sets these policies on how things are governed and how medical schools rank their applicants.

From 1994 until 2006 the AFMC only allowed Canadian medical graduates from their medical schools in the first iteration of our match. There are two iterations. The first fills as many vacancies as possible, and then leftover positions carry forward and there's a much shorter timeline for the second iteration. Up until 2006, only CMGs, or Canadian medical graduates, could participate in the first iteration. As of 2006, international medical graduates were also participating in the first iteration.

Since 2006, when the AFMC opened up their policy and allowed the schools to rank IMGs in the first iteration, most provincial Ministry of Health-funded positions for IMGs were in separate streams. Prior to 2006 CMGs were competing against IMGs for available positions in the second iteration. However, since 2006, when the IMGs were allowed in the first iteration of the match, most provinces have parallel streams. There are designated positions for IMGs in the first and second iteration of the matches, so Canadians are not competing with IMGs for these positions.

Since that time CaRMS has seen a dramatic increase in the number of IMGs participating in the match. In 2003 there were approximately 600 IMGs in our match. By 2007 the numbers had increased by more than 1,600, and have remained somewhat constant since that point; between 1,600 and 2,000 IMGs are participating in our annual residency year one match.

Since 2008 CaRMS has been the lead partner in an annual IMG information symposium. We recognize that IMGs are geographically dispersed. They don't have peers who are studying medicine with them, nor the ability to ask one another, as CMGs do, about what the match process is all about, what requirements are necessary regarding eligibility. So two years ago we organized the first annual international medical graduate symposium in Toronto.

We found that two-thirds of IMGs in this country are located within one hour of the greater Toronto area, which is very good for us to organize an annual event. Again, we had the Medical Council of Canada and Fleur-Ange's organization, FMRAC, involved, and about six or seven other organizations, including the Ministry of Health for Ontario, through HealthForceOntario. It's an opportunity for all our organizations to share information face to face with IMGs. Over 400 of them attend annually. But it's also a point for them to give us feedback, and the emotions are raw.

● (0915)

CaRMS also participated in the first annual IMG symposium held in Quebec this past year.

Early in this decade, CaRMS identified a subset of IMGs who were Canadians studying abroad, or as we refer to them, CSAs. They're defined as Canadian citizens or permanent residents who are studying medicine outside of Canada and in the U.S. Through a 2009-10 grant from Health Canada, CaRMS has been researching this group of Canadian students who elect to study medicine, and we've been studying them in more than 25 countries around the world.

I'll give you some statistics on international medical graduates. Our international medical graduate community includes CSAs or Canadians studying abroad. We do not differentiate between the two groups, so the CSAs are a subset of the IMG community.

CSAs represented 24% of the first-time IMGs participating in the match in 2008. In 2009 this number increased to 31% and in 2010 that number is now 40%. Again, we have approximately 1,600 to 2,000 IMGs participating in our annual match, and the number of matched IMGs in 2007 was 298, in 2008 it was 353, and in 2009 it was 392.

That's the end of my presentation.

● (0920)

The Chair: Thank you very much.

We'll now go to the Federation of Medical Regulatory Authorities of Canada, and Fleur-Ange Lefebvre.

Dr. Fleur-Ange Lefebvre (Executive Director and Chief Executive Officer, Federation of Medical Regulatory Authorities of Canada): Thank you very much, and thank you for the opportunity to represent some of the information we gave you on December 9 and to give you a bit of an update.

I'm presenting today on behalf of the Federation of Medical Regulatory Authorities and its 13 members, which are the provincial and territorial organizations. It was established by legislation to serve in the public's interest by setting standards of practice and professional conduct and determining the qualifications to obtain and maintain a licence to practise medicine.

In December you received a copy of the latest draft agreement on national standards for medical registration in Canada. A few things have changed since then, but it's still a draft and we're aiming to do a bit of approval at our AGM in June.

We have defined the Canadian standard as the set of academic qualifications that automatically makes an applicant eligible for full licensure in any Canadian province or territory. To achieve the Canadian standard, the applicant must have four things. The applicant must have a medical degree from a recognized medical school; we rely on two lists of Canadian and international schools. The applicant must be a licentiate of the Medical Council of Canada. The applicant must have satisfactorily completed a discipline-appropriate post-graduate training program and ensuing evaluation by a recognized authority. We haven't quite defined “recognized” for that, but we're working on it. Finally, the applicant must be certified by either the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada. That is the Canadian standard.

On the topic of international medical graduates, the recently signed agreement among the regulatory authorities covers not only the Canadian standard but additional standards for recognition of international medical graduates seeking licensure in Canada. Medical regulatory authorities agree that IMGs who do not meet the Canadian standard may initially be eligible for provisional licensure.

Our work to develop the national standards for provisional licensure includes four areas of work. One is the eligibility criteria, or what gets you into the system to begin with. Two is the pre-licensure assessment. If that goes well, there are supervision requirements for the applicant or the licensee for the duration of that provisional licence. And finally, there is a formative assessment that will take the applicant from a provisional licence to a full licence.

This work is pivotal to our goal of meeting the requirements under chapter 7, which is labour mobility in the agreement on internal trade. It is ahead of the expectations stated about the medical profession in the pan-Canadian framework for the assessment and recognition of foreign qualifications.

We are working with the two national organizations that are responsible for the quality of family medicine and other specialist medical training in Canada. I mentioned them before. They are the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada. Both are doing what they can with their resources to determine the equivalency of medical training programs in other countries.

However, we know that we'll never have a complete picture of the equivalency, or even reasonable equivalency, of medical training around the world. Medical regulators in Canada will always have to rely on made-in-Canada assessments tailored to what is known about the quality of each international medical graduate. A tailored approach to assessments will be much more efficient than a one-size-fits-all approach, in our opinion. Although that might mean a faster track for graduates from some countries, we believe we can create a standardized approach that will be used across the country and that will be defensible both from the academic perspective and a human rights perspective.

The extensive experience and commitment of medical regulators in this country to foreign qualifications assessment and recognition is demonstrated by the licensing statistics in the table that was distributed today. We can get into this table later on, but you should have this before you—I translated it myself—and it will show you some numbers. We have asked our medical regulatory authorities to now start separating full and provisional licences for graduates of the Canadian system and international medical graduates.

You can do a bit of arithmetic and see that in some jurisdictions last year there were more international medical graduates who received new licences than graduates of the Canadian medical education system. We can talk about that a bit later.

This is a process in evolution, as we move to national standards. The way that people capture and upload the data to us will also be standardized.

● (0925)

Provincial and federal departments of labour and of health are very aware of the intensity with which medical regulatory authorities across Canada are developing a renewed national standard for physician registration, one that includes a common approach to the recognition and licensing of international medical graduates.

I can't repeat the next little bit enough: Medical regulatory authorities are tasked by governments in legislation to ensure physicians provide safe and effective care. They must walk a fine line between expectations for quality care and for access to any service at all in some parts of Canada.

Thank you for you attention. I will be pleased to answer questions in both official languages.

The Chair: Thank you very much.

We'll now go to Dr. Bruce Martin, who is with the J.A. Hildes Northern Medical Unit.

Dr. Martin, I understand that you're going to talk about not only the graduates, but as you couldn't make it to the last committee, you're going to talk about the remote areas as well—just to give us some insight into your expertise. Is that not correct?

Dr. Bruce Martin (Doctor, Faculty of Medicine, University of Manitoba, J.A. Hildes Northern Medical Unit): That is correct.

The Chair: Okay, thank you.

Dr. Bruce Martin: Thank you very much for having me here. I apologize for not being able to attend on Tuesday, when you were discussing issues of health human resources in rural and remote communities and their populations.

By way of personal introduction, I am a family physician. As a Canadian, I probably manifest some of the issues and attributes of individuals who've come through a system addressed to assist Canadians and other practitioners to work in remote northern communities. This was a significant part of my undergraduate medical education, part of my post-graduate medical education, and for more than 20 years I have served in remote populations, principally those of aboriginal ancestry in Canada.

By way of introduction of personal involvement, I'm with the University of Manitoba faculty of medicine. I have two roles there: I'm the associate dean of undergraduate medical education; and I'm also director of the university's J.A. Hildes Northern Medical Unit, a population and public health department initiative created in 1970 to address the underserved populations of northern Manitoba and what used to be the NWT, now the central region of Nunavut.

I have before me some speaking notes, which members have received, and would like to briefly introduce the challenges of health human resources in rural and remote populations.

The Chair: Dr. Martin, could I just interrupt you?

Dr. Bruce Martin: Sure you can.

The Chair: They have not received these, simply because they're not bilingual, but we'll make sure everyone gets a copy.

Dr. Bruce Martin: I apologize for that.

The Chair: That's okay.

Dr. Bruce Martin: I'd like to therefore address what I would refer to as an inextricable triad. When we look in northern remote populations we should be discussing not just health human resources but the contribution of the health care system, of the health system itself. I'll provide you some brief details. I will discuss disease and illness burden, and how that influences our ability to provide care, but the centre of that triad should be considered the patient and the community.

Regarding health human resources, the circumstances have been very well described historically and the current situation regarding health human resources has been unfortunately accurately predicted. I would reference very specifically the Royal Commission on Health Services, or Hall commission, in 1965, in which in volume two Justice Emmet Hall had a very lengthy subset of his commission and that of his commissioners regarding health human resources in northern populations.

This was followed on a number of occasions, but very explicitly by a report of Barer and Stoddart. Many of you are aware of the report of 1991, but they also did a report for a precursor of this committee in 1999 that looked at the determinants of health human resources and recruitment and retention for northern and remote populations. Both of those documents, and many others, predicted the deficit that we face. The deficit we face in health human resources now is not only absolute in numbers, but has very significant deficits in terms of the relative mix of health human resources and providers, and there is also a substantial deficit in skill set, which I'll return to.

The determinants of recruitment and retention are also very well and historically documented. There is a four-pillar approach to recruitment and retention that speaks to the personal interest of health providers and their background, their appropriate training, the attributes of communities in which they work, and the working conditions within those communities.

The solutions that we must have to address these deficits in health human resources are increasingly clear. They've been articulated before in fora such as this. There must be a clear emphasis on collaborative and inter- and intra-professional approaches to care. By that I mean working together, whether we're members of one profession or members of another profession. We must have innovative strategies in the undergraduate and postgraduate education of health professionals who wish to serve underserved populations, principally focusing on regulated health professionals.

There have been some creative strategies. There is a very innovative approach in the University of California, Los Angeles, called UCLA PRIME. There's another innovative approach that's been supported by your government and that of the provincial government in Manitoba called the Manitoba Northern and Remote Residency Program. We must also focus on the creation of a supportive competency-based and integrated community workforce. I'd be pleased to address questions in that regard.

Regarding the disease and illness burden, which I trust you spoke of or remarked upon in your previous meeting this week, it is clear that there are evolving patterns of illness in northern remote communities and they are profound determinants of a capable workforce. There are descriptions of the epidemiology, or the pattern of disease, and these unfortunately are following a predicted pattern of evolution.

We are seeing emerging new infectious diseases, but tragically we're also seeing a resurgence or a reawakening of previous infectious disease outbreaks. We're seeing chronic disease in numbers we have never seen before. We've seen increasingly social maladies in northern and remote communities, regardless of the ancestry of people of those communities, and those maladies embrace spiritual and mental health issues. They embrace issues of addictions. They embrace issues of self-harm and interpersonal violence.

Superimposed on the disease burdens are the broadest determinants of health, whether they be housing, employment, or education. Perhaps there's a genetic propensity to illness, but all of these impact communities and often intensify the disease issue, resulting in a profound illness burden, meaning the manner in which or the degree to which individuals face their disease.

● (0930)

The third component of the triad I discussed, or introduced, is inextricably bound to those first two: the health system. Quite tragically, the health system in northern remote settings is often and very accurately described as fragmented, under-resourced, and subject to jurisdictional complexity, ambiguity, and resultant neglect of populations.

There is clearly a need for aggressive so-called “system engineering”, a term that was first used in industry but is now extensively embraced in the Canadian and American health care systems, as articulated by the Institute of Medicine in the United States. Those approaches to aggressive system engineering need to address the contributors to what has now been called in the literature, “clinical inertia”. This is a manifestation of the fact that we may know what to do about disease either at the personal level or community level, but for one reason or another we just don't seem to get moving. The term “clinical inertia” is increasingly used in a very appropriate description of northern remote communities.

I very humbly think we need to revisit the Hall commission of 1965. Justice Emmett Hall and his commissioners in fact wrote quite clearly about the challenges of northern remote populations, and I would admit that in the last 45 years there has been a change in linguistics but a change in the need to address it, and system resources must be brought into play such that we can address the evolving patterns of illness.

Last but not least, I would say that patients and the communities always need to be engaged and empowered so that we can move along to address the challenges, the tragedies, and the predictable outcomes in northern remote populations.

Thank you very much.

● (0935)

The Chair: Thank you so much, Dr. Martin. I gave you quite a bit of extra time because I knew you were presenting both sides of it.

Dr. Bowmer.

Dr. Ian Bowmer (Executive Director and Chief Executive Officer, Medical Council of Canada): Thank you very much, Madam Chair. I really appreciate the opportunity to appear once again before this committee on behalf of the Medical Council of Canada.

As Madam Lefebvre noted, we really do not have a single Canadian licensing system; rather, we have 13 independent jurisdictions. While there is a Canadian standard, each jurisdiction still has the ability to make multiple exceptions.

The Medical Council of Canada was actually founded in 1912 to establish a single acceptable national qualification for these jurisdictions for the practice of medicine in Canada.

At this moment in time we have heard of the Canadian standard and the acceptability of the examination process to each of the 13 jurisdictions. Each graduate from a Canadian medical school must take our examinations prior to entering clinical practice. As Dr. Varastehpour noted, international medical graduates must complete one or more of the Medical Council's examinations to be eligible for licensure.

Each province and territorial regulatory authority determines which examination comprises the minimal requirement for licensure. Every year, over 12,000 candidates, both Canadian graduates and international medical graduates, take Medical Council examinations. These assess medical knowledge, clinical skills, and professional behaviours required of an independently practising physician.

After passing the final examination, the qualifying examination, part II, and meeting all other credentialing requirements, the candidate is awarded the licentiate of the Medical Council. It is one of the requirements that provincial and territorial regulators require before issuing a physician a licence to practise in Canada.

The council has taken the lead on several successful collaborations with the Government of Canada, through Human Resources and Skills Development Canada, Health Canada, as well as partner medical organizations. We've worked together on measures to more easily integrate international medical graduates into practice in Canada.

One such collaboration resulted in the launch of the Physician Credentials Registry of Canada. This is a collaboration between the Medical Council and the Federation of Medical Regulatory Authorities of Canada, and it has received funding through HRSDC. It is a national repository for source-verified credentials. We've been operating this now at the Medical Council since 2007 and are processing approximately 380 diplomas and credential documents per month.

Physicians can submit their documents prior to emigrating to Canada, and international medical graduates applying to one or more jurisdictions can choose to share their verified credentials with multiple organizations at once through the repository, saving both time and effort. While time for verification depends on the source institution abroad and the type of document, the average is approximately 81 days for medical degrees and 108 days for verification of postgraduate education. Of course, there are countries in the world where this is not feasible, Afghanistan being one and Iran another. We do have alternative methods to be able to demonstrate that an individual has graduated from an institution in these countries.

At the moment, the repository is only available to international medical graduates, but our intention is to open it up to Canadian physicians.

The opening of an account with the repository is only the first step for international medical graduates. The second step, as the presentation by Dr. Varastehpour noted, is the Medical Council evaluating exam. The reason for this is that some countries around the world do not have accreditation processes. We in Canada and the U.S. have a joint accreditation process for medical schools that is quite rigorous. Therefore, the need for assessment of physicians' knowledge was considered essential, and in 1979 the Medical Council collaborated with the Government of Canada to offer this examination abroad. Unfortunately, it was only offered through embassies and consulates in about ten places around the world. Since 2008 we have had a computer-based test, now offered in 73 countries at 500 sites, so candidates do not have to travel outside of their country of origin to take this examination.

● (0940)

The examination was always intended for international medical graduates prior to their emigration to Canada. However, at the present time, 50% of those taking our examination do so from inside Canada. Our data show that if a candidate fails this examination one or more times, she or he has a low probability of completing the licensing process, probably less than 35%, as opposed to passing this examination the first time, when the person then has a more than 75% chance of completing the licensing process.

We believe that the federal government should benefit by requiring potential licensure applicants to provide evaluating examination results for consideration at the time of their immigration application.

Dr. Varastehpour is correct that this is an expensive examination. We do it through a delivery system. However, we are also offering a self-assessment examination based on that exam, which individuals can take. We have multiple forms for this. It costs $60 to take this over the Internet, and the individuals get feedback on whether or not they would be successful.

The other aspect of assessment, of course, is the clinical skills. We've been in a collaborative partnership of national medical organizations and the various governments to provide an assessment of clinical skills. These are the communication skills and diagnostic skills.

The final area where we have collaborated has been to establish a national registration process that can be done through the web. This process could start prior to candidates coming into the country as well.

I'll close there. Thank you, Madam Chair.

The Chair: Thank you, Dr. Bowmer.

We'll now go into our first round of questioning, of seven minutes for the questions and answers.

We'll begin with Dr. Bennett.

Hon. Carolyn Bennett (St. Paul's, Lib.): Thank you very much.

Thank you all for coming.

I'd like to begin by reading the communiqué from the 2004 health accord, of which one of the items was the strategic health human resources action plans.

> There is a need to increase supply of health care professionals in Canada, including doctors, nurses, pharmacists and technologists. These shortages are particularly acute in some parts of the country.
>
> As part of efforts to reduce wait times, First Ministers agree to continue and accelerate their work on Health Human Resources action plans and/or initiatives to ensure an adequate supply and appropriate mix of health care professionals. These plans and initiatives will build on current work in the area of health labour relations, interdisciplinary training, investments in post-secondary education, and credentialing of health professionals. Recognizing the important contribution of health care providers in facilitating reforms, First Ministers commit to involving them in their work in this area. To facilitate better planning and management of HHR, First Ministers acknowledge the need to foster closer collaboration among health, post-secondary education and labour market sectors.
>
> Federal, Provincial and Territorial governments agree to increase the supply of health professionals, based on their assessment of the gaps and to make their action plans public, including targets for the training, recruitment and retention of professionals by December 31, 2005. Federal, Provincial and Territorial governments will make these commitments public and regularly report on progress.
>
> The federal government commits to: accelerate and expand the assessment and integration of internationally trained health care graduates for participating governments; targeted efforts in support of Aboriginal communities and Official Languages Minority Communities to increase the supply of health care professionals for these communities; measures to reduce the financial burden on students in specific health education programs; and participate in health human resource planning with interested jurisdictions.

We need to be reminded of this because this committee has to recommend what the federal responsibility is in moving forward.

My understanding is that a federal-provincial-territorial committee was charged with doing this. I have concerns that the federal participation in that committee has been modest at best. It's better than the national pharmaceutical strategy, where they haven't even appointed a federal co-chair.

If you were writing the recommendations about how the federal government needs to redouble its efforts in taking to heart—obviously in terms of aboriginal health human resources—the areas in which the government needs to show, in terms of the international medical graduate slots, supervised slots, an ability to assess people early, as Ian has said, and if they aren't going to make it, to be able to move them early to physician assistance or hospital lists or be able to use their skills in their own language...

I know what the report card from most people is, in terms of the federal participation in this. Either in this hearing now or for you to forward to us, we would love to know your recommendation on the role the federal government must play in moving forward. Clearly, poaching people from province to province isn't working.

How do we get more health human resources, and what role can the federal government play?

● (0945)

The Chair: Who would like to begin with that question? Dr. Bowmer?

Dr. Ian Bowmer: I'll jump in, Madam Chair.

First of all, I think assessment is absolutely crucial, and if it can be done in the country of origin and given some sort of direction, that's wonderful. What I think is perhaps lacking in Canada at this moment is the capacity to provide remedial training for individuals who have taken a long time to move through the exams and need some catch-up time, maybe because they have spent two years learning French or English and therefore are no longer eligible for licensure. That can be anywhere from three months to a full residency. The capacity for those individuals is not increasing, and I think that was something Dr. Varastehpour pointed out.

When we hear there are 1,600 or so international medical graduates applying for residency—therefore, by definition, they have been identified as needing remedial activity—and only 350 or 400 are getting in, we have a capacity problem in the country.

Hon. Carolyn Bennett: Could the federal government pay for those slots and help the provinces out?

Dr. Ian Bowmer: Health is a very tricky issue in Canada, Dr. Bennett, as you know. I'm a former dean of medicine, and I would have loved to have had the federal government paying some residency slots when I was in Newfoundland and Labrador. However, I'm not sure my government at the time would have appreciated that intrusion.

There is a need, and perhaps as a program for international medical graduates there is a way in which Immigration Canada or the federal government can have a role, but I am not sure how that can be best applied.

The Chair: Ms. Lefebvre.

Dr. Fleur-Ange Lefebvre: Thank you.

I think there are two things, and both of them are pretty similar to what Dr. Bowmer has already said. On the capacity issue, assessment in the country from which the IMG is applying to enter Canada is important, but it's also important to realize that there will be a clinical observation period, and those are extremely resource intensive. If we're trying to standardize how this is done across the country, there may be an opportunity to pool resources. There is only so much you can do in a centralized or regionalized system because at one point it has to be practice-relevant. It has to happen in the setting for which the licence will be awarded, but there are several issues that could be pulled together in a form of either a centralized or regionalized assessment modality for the period of clinical observation. You cannot bypass that before you award any kind of licence.

The second issue comes back to the expectations. We hear these stories all the time, particularly at the IMG symposium: “That isn't what I was told before I came to Canada”. That is frightening.

We think the Foreign Credentials Referral Office is doing a wonderful job, because they are revving up the information that is being shared. However, what I keep telling them is they are now dealing with a group of people who have already been approved to come to Canada. We need to talk to these people before they make the decision to come to Canada.

That's what I'd like to say.

● (0950)

The Chair: Thank you so much.

Monsieur Dufour.

[*Translation*]

Mr. Nicolas Dufour (Repentigny, BQ): Thank you very much, Madam Chair.

I also want to thank all the witnesses for being here today.

Of course, you will understand that, when it comes to the federal government's involvement, we take a totally different view than the Liberals. Mr. Bowmer had it right earlier when he said that, first, each province must decide on its own evaluation. When you say you are not so sure that your government would have appreciated certain intrusions, I totally agree. I am not sure whether my government would appreciate some of those intrusions either.

That being said, I just have a question for Bruce Martin. In terms of the approaches taken by California and Manitoba regarding their faculties of medicine in rural areas, we had an extremely interesting debate at the beginning of the week. Could you explain in a bit more detail the approaches that California and Manitoba have taken?

[*English*]

The Chair: Who would like to do that?

Dr. Martin.

Dr. Bruce Martin: Thank you very much.

I could describe the program at the University of California, in Los Angeles. When the State of California recognized the need to increase the number of medical students and therefore practising physicians, it made a determination that making more of the same would perhaps not address the needs in under-served populations. So UCLA developed a program called UCLA PRIME. It selectively recruited individuals who would do two concurrent degrees: an MD degree to contribute towards the practice of medicine, and a master of public health. It's an extended five-year program instead of four years, but it gives the individuals a distinctly additional skill set to address the needs of distinctly different populations.

I believe they are now close to their first iteration. It is selective recruitment, unique curriculum, and additional skill sets so when they graduate with the MD degree and post-graduate training they have additional skill sets to move into communities of higher need.

The program in Manitoba is a unique and innovative approach. It has not yet been announced by the federal government. The announcement by the minister was to have been last week, and it has been moved to the end of April.

The federal government is partnering with the University of Manitoba, the College of Family Physicians of Canada, and the Government of Manitoba to increase the number of residency positions and the intensity of the training of a select pool of family practice residents to address the needs of northern and remote communities. They are generally those of aboriginal ancestry in northern Manitoba, Nunavut, and a portion of the Northwest Territories.

This is unique. It is the first time, to my knowledge, that the federal government has embarked on a contribution to residency education. There are ten provincial spots that are funded. And for this intake, there are an additional five funded federal spots. Next year there will be ten federal spots funded, for a total complement of twenty post-graduate trainees. Part of their training will be in southern Canada, with a traditional program in family medicine. An extensive component will be trained in remote communities, precepted by experienced physicians in remote and specifically aboriginal health care. These are not just family physicians, but specialists, medical specialists, and other health care professionals who are embedded within communities.

I trust that answers your question.

● (0955)

[*Translation*]

Mr. Nicolas Dufour: Thank you very much. I have no other questions.

[*English*]

The Chair: Thank you, Monsieur Dufour.

We'll now go to Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis (Winnipeg North, NDP): Thank you, Madam Chairperson.

Thanks to all of you.

Let me start with the Manitoba connection first. I think the northern medical unit is a model that could be used in our report to the House of Commons for action planning in the future.

Dr. Martin, you touched on the success that Manitoba has had in terms of recruiting medical graduates, and the retention rate for post-graduate studies is growing as we speak. There was a recent news report by Jen Skerritt on the success we've had in that regard. I'm pleased to hear that the federal government is involved at that level.

You addressed a broader issue as well, and that is the question of clinical inertia. That's something we've heard over and over at this committee, especially as we've dealt with H1N1. We'll hear it again when we discuss tuberculosis in a couple of weeks.

I know that with the limited budget and scope of the northern medical unit you've been able to overcome that clinical inertia and attempt to do some systemic engineering of the system. What lessons would you give us? What have you learned? What can be applied to the rest of the country? What role could the federal government play in terms of resourcing and leadership to take it to the next step? I know it's a broad question.

Dr. Bruce Martin: It is a broad question. Perhaps, if you don't mind, I'll start with an opening statement.

I very much appreciate your commendation of the university's northern medical unit's work, but I would also caution you by saying that in my decades of involvement in university-affiliated programs, we still are falling remarkably short. We're falling short in recruitment and retention, and our percentage of complement of practitioners is profoundly low. We fall short in our ability to address some disease entities, although recent published peer-reviewed literature has identified that where we work and where similar organizations work, the outcomes are better, but the outcomes are far from what the Canadian mainstream population faces.

With that apologia, I would say that yes, we have made some movement in the decades we've been involved in care, as have other Canadian university medical school affiliated programs, but we need to take a look at that model, intensify it.

Where can the federal government help? I think we need your assistance and that of the provincial and territorial leaders to clearly define the health human resources need in terms of skill set. I think we need to identify what the competencies really are for health human resources or health professionals' communities, whether they be physicians, dentists, rehab therapists, nurses, or unregulated health professionals. We need to establish educational programs to assist individuals in getting that skill set and maintaining their competency.

I think unfortunately there's often an underestimation of the skill set, and the mainstream education system does not address the evolving patterns of epidemiology in the communities, so that physicians, nurses, and others are profoundly challenged to address the needs. This becomes an issue for recruitment but also for retention, as they feel increasingly comfortable in the needs they must have.

So increasingly a partnership between the federal-provincial-territorial leadership, the academic institutions, and the regulatory bodies that assist us in attaining and maintaining competency in a very unique and challenged environment would be the kind of assistance we need.

I think it's generalizing it and revisiting the liaisons between academic health science networks, medical schools, health professional schools, and northern and challenged populations, or subsets of our population, realigning and revisiting that model but also building on the so-called social accountability needs of our medical schools and other health professionals to recognize they need to be educated in and practise with communities regionally, nationally, and internationally to share the expertise that we have and to intensify the expertise to the benefit of the population.

Does that answer your question?

● (1000)

Ms. Judy Wasylycia-Leis: Yes, it does. I think it would be useful if you could actually provide any background information about the northern medical unit to this committee for our deliberations. I think that might just help us as we develop our paper and proposals. Thank you.

Dr. Bruce Martin: Thank you.

Ms. Judy Wasylycia-Leis: Do I have a little bit more time? I know we'll get a second round.

The Chair: You have two minutes.

Ms. Judy Wasylycia-Leis: Dr. Varastehpour's comments were so forceful and strong that I think I'd like to hear some responses from others about his frustration. Looking at the statistics, it's clear Canada seems to have fallen down on the job over the last several years. According to our researchers, IMGs represented about 23% of the total physician workforce in 2007, and that's a decrease from 33% in the late 1970s. So something's going wrong. I hear what everyone's saying about the system and doing the best you can, but I guess I'd like to know, when there is a level playing field, how do IMGs not get into the system?

The Chair: Dr. Bowmer, I think you wanted to make a comment on that.

Dr. Ian Bowmer: Yes. Thank you, Madam Chair.

I think it would be inaccurate to say that something's going wrong because the percentage of international medical graduates has decreased to 22%. During that same time, the output of Canadian medical schools has almost doubled. So the relative percentage has decreased, but if you look at the actual numbers, the numbers have been either steady or slightly increasing.

Ms. Judy Wasylycia-Leis: But what if you put that in the context of the shortage of family physicians in Canada?

Dr. Ian Bowmer: This is another issue. And thank you for opening that one up, because I think one of the major problems we have not discussed in this country is the fact that it may not be the numbers of doctors that is essential, but how the system works, and we're not talking about other health professionals and their roles in the health care of populations.

Work has been done on the fact that, for example, Germany has poorer health outcomes than we do, but they have twice as many doctors per population as we do. Not enough emphasis has been put on re-engineering the system. Canadian medical schools are moving to interprofessional educational models, and we are trying to do some assessment on this.

I think we have to be really careful about the numbers. Dr. Varastehpour pointed out that we have 250,000-plus immigrants a year. At least 500 to 750 of those should be and would be physicians. There should be a commitment, I think, to integrating those physicians into the country. But the fact that the percentage has dropped, one could argue we're moving to sustainability on those percentages as well, and that was another aspect of ethical recruiting of international medical graduates. My own feeling on ethical recruiting is if individuals are recruited, we have an obligation to integrate them into the country's practice.

Madam Chair, a pan-Canadian HHR framework was negotiated a number of years ago, and I was involved in some of the data that went into that, but I haven't heard anyone talk about that.

The Chair: Thank you, Dr. Bowmer. There was one, that's for sure.

But we'll have to go on now to our next panel member, and that's Mrs. McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair.

I'm appreciating the fact that our analyst gave us a process around how international medical graduates come to Canada. There are many steps, and it's quite complicated in terms of organizations. I see all the steps along the way. Probably there are opportunities for improvement in terms of the process.

Mr. Boone, how many spots are available each year in each stream?

● (1005)

Mr. Jim Boone: I can't speak to that. I don't have the statistics in front of me, so I can't tell what the trends are for the increased number of spots in IMG positions, how many remain vacant afterwards, but I can certainly mine that data and send it to the committee.

The Chair: Would anybody else like to make a comment on that? Does anybody also have insight into it?

Do you want to go on to your next question, Ms. McLeod?

Mrs. Cathy McLeod: Okay.

Out of the people who apply for a spot, many are turned away. We talk about the costs of training, but how much is also a system capacity issue, in terms of having the capacity to open spots versus the dollars? Is anyone able to speak to that question?

The Chair: Who would like to tackle that one?

Dr. Martin.

Dr. Bruce Martin: I'm getting a nod for Dr. Bowmer.

I'm speaking now in the context of being an associate dean, undergraduate medical education, and I look at Dr. Bowmer as a previous dean, as he's mentioned, so I'm careful how I answer. This is not specific to my presentation about the northern medical unit and northern health care.

Capacity is a significant issue. As the Canadian medical schools and a new Canadian school have entered into the situation, as the number of undergraduate medical students is being very significantly increased, and there's a concomitant increase in the number of post-graduate training positions, there are huge challenges in the capacity of the health care system to educate those individuals and attain standards of quality education as reviewed by our undergraduate accrediting agencies and our post-graduate accrediting bodies. That might be explored by this committee with other leadership in undergraduate and post-graduate education. And this is not solely in medicine, but as faculties of medicine embrace education of other health professionals, whether they be physician assistants, nurse practitioners, or advanced skills in others, there are issues of capacity.

Mrs. Cathy McLeod: I have heard there have been some changes over time in terms of assessment prior to coming to Canada. For people who are coming to Canada with qualifications to a much greater degree, have a number gone through a pre-assessment process and have a good understanding of where they're going to fit into the system? Have things improved? It sounded as if over the last few years we've had some improvements there.

The Chair: Who would like to take that comment?

You're asking very hard questions, Ms. McLeod.

Mr. Boone.

Mr. Jim Boone: Each province has its own pre-assessment program, but each of them has defined its own way of assessing foreign-trained physicians. It's difficult if you're an IMG and you're interested in applying to multiple provinces. It gives them their best possible chance: the more programs they apply to, the more universities, the better chance they have. However, if they're assessed in B.C., for example, that's an enormous amount of investment of their own time resources. You have to be a resident of B.C. to be assessed there so they can't realistically apply to any other province. Likewise with Quebec: you're assessed as an IMG in Quebec, and it's difficult to apply outside Quebec because you have to be a resident of Quebec to be assessed in Quebec. Likewise in Ontario.

So we're really pigeonholing the IMGs provincially and not allowing them the flexibility to apply to positions across the country, which reduces the selection and reduces the opportunity for the applicant.

● (1010)

The Chair: Thank you so much.

We'll now go to Dr. Duncan.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Madam Chair, and thank you to all of you for coming.

I'm going to focus on licensing exams and how long it takes, etc. What is the cost of the licensing exams and what is the average number of years an IMG waits before taking them?

Dr. Ian Bowmer: I'm not sure I can answer that totally accurately, Madam Chair, but the current cost of the evaluating exam is $1,200. The current cost of the qualifying exam part one is $800, and the current cost of the qualifying exam part two is $1,600, which in terms of the cost is almost the same as the three-step examination the U.S. administers. But Dr. Varastehpour is correct that the Canadian graduate does not have to do the evaluating exam.

The time for an international medical graduate to move through the system depends on whether or not they pass.

Ms. Kirsty Duncan: Sorry, that wasn't the question. What is the average number of years they wait before taking the exams?

Dr. Ian Bowmer: They're eligible as soon as they... We do not require their documents to be source-verified prior to taking the exam.

Ms. Kirsty Duncan: I know that.

Dr. Ian Bowmer: So they can take that immediately, and we offer that six times a year.

Ms. Kirsty Duncan: In my community I have now met 100 IMGs, actual count, who have not been able to afford the exams. When they've brought their children over they are working two jobs and they cannot afford the $1,200. Some have waited four and five years to have the money to take the exams. I'm wondering if we have data on that.

Dr. Ian Bowmer: I don't know the people who don't take the exam; I only know the people who do. But I would say on the issue of the cost that we are a not-for-profit charitable organization, and at this moment all the exams are cost-recovery, except for the qualifying examination, which is subsidized by an endowment the council has. So in terms of the cost as an issue, if that's an access issue, that is a problem for those individuals.

I just point out that any of us—and I'm a licensed physician in Newfoundland—if we do not practise for two years, have to do remedial work. So delaying a candidate for more than two years automatically requires them to have further education. So that is an issue.

Ms. Kirsty Duncan: Have some of the reasons for the delays been looked at? One of them is certainly the money. Were there other reasons for delaying?

Dr. Ian Bowmer: First of all, I think people should be encouraged to take this exam offshore so that they are not in the position of having to find alternative work. My advice to international medical graduates, if they're here, is to keep going back to their home countries to practise, so they're at least presenting themselves as fully practising physicians during the time that they're waiting for the exams.

A person who passes can actually get through the examination system within about 18 months. It is possible to do it in 12 to 18 months, but they would have to pass each exam, and the timing would... We offer part one twice a year and part two twice a year, so it is possible to do it within 18 months.

Ms. Kirsty Duncan: What is the average pass rate for an IMG compared to a Canadian graduate?

Dr. Ian Bowmer: If you look at the performance on the part one exam—and they have to have passed the evaluating examination to have done that—about 90% to 95% of Canadian graduates will pass, and it's somewhere in the neighbourhood of about 65% to 70% for IMGs if they pass part one the first time. It drops down to about 50% to 60% if they've taken more than one opportunity to take the exam.

● (1015)

Ms. Kirsty Duncan: That's—

The Chair: I'm sorry, Dr. Duncan; your time is up.

Thank you, Dr. Bowmer.

Now we'll go to Mr. Brown.

Mr. Patrick Brown (Barrie, CPC): Madam Chair, like Ms. Duncan, I have concerns about medical graduates. I've met some in Barrie on some of the position recruitment tours, and they have really been challenged with the process in Canada. I think it's important that we understand it a little better.

First, what are the costs for the medical equivalency exams in Ontario, or in Canada, for both the exams and the books? What is the cost of the exams for foreign-trained doctors to become accredited in Canada ?

Dr. Ali Varastehpour: It's $5,000, roughly.

Mr. Patrick Brown: It's $5,000. What is the cost of the books?

Dr. Ali Varastehpour: You can study as many books as you can. The single recommended textbook is about $150.

Mr. Patrick Brown: How many textbooks do you need?

Dr. Ali Varastehpour: Myself, I studied from American books because I'm USMLE-certified, so I knew where to look. For me, that was not the issue, but if you come from eastern Europe, as I do, where we didn't have one single written exam, you are seeing multiple-choice questions for the first time in your life. It takes some time to get used to that. That's why I was talking about bridging programs during the course of my conversation. I passed with 90%, but there are people who pass it with 100%. That does not mean anything.

In order to safely practise medicine, and I'm sure even Dr. Bowmer would agree, even 60% on the evaluation exam is enough. People are coming here with an evaluation exam taken in their home country, at any time and at any number of attempts with any school, and they pick and choose their specialty. This is the crux of the matter.

Mr. Patrick Brown: I know a couple of stories in my riding. They're both doctors from eastern Europe, and because they were making $10 an hour, it took them three or four years to save up enough money to pay for the exams and the books. It sounds like a very arduous process. Hopefully we can look for ways to alleviate this situation.

Fleur-Ange, maybe you could help me on this. Do you know how many foreign-trained doctors have passed the equivalency exams but have not been able to be placed into residency? One thing we've heard is that there is certainly a lack of residency spots for foreign-trained doctors. On an annual basis, do we know whether that gap is getting bigger or smaller?

Dr. Ali Varastehpour: The majority of foreign-trained doctors, even those who are successful through their licensing exams, do not get a position. As a matter of fact, I will tell you about one of my colleagues who is very, very bright. I personally vouch for her. She is like a computer, literally. The whole Canadian system cannot produce somebody like this lady, and she got a job at post-match, like a charity. It is barely in family medicine. The reason is that Canadians are not really interested.

Mr. Patrick Brown: I only have five minutes and I'm just trying to get the numbers out.

Do we know what the numbers are in Ontario right now, or in any of the provinces?

Dr. Ali Varastehpour: I can probably answer you that the majority are not successful. I don't have numbers.

Mr. Patrick Brown: I heard someone mention to me that it was about 700 who had passed each year and there are only about 175 foreign-trained residency spots. Does that number seem correct in Ontario?

Dr. Ian Bowmer: Madam Chair, the province of Ontario actually funds 200 international medical residency slots per year, and that's not including other positions that might be available. That is a number I do know.

Mr. Patrick Brown: How many pass? 175 and 200 are very similar, but how many people have passed equivalency exams for a foreign-trained medical doctor? If it's 200 we have no problem, but if it's 1,000 then we have an issue.

Dr. Ian Bowmer: This is a paradox in Canada. We don't actually work on provincial statistics. When we're looking at the match, we look at Canadian statistics at the match level—

Mr. Patrick Brown: Do we have Canadian statistics on that?

Dr. Ian Bowmer: We know that... I mean, Mr. Boone has—

Mr. Jim Boone: There are approximately 1,600 IMGs that go through the match process on an annual basis. There are more in the system, but because they're waiting on exam results and things, they don't all go through with the first iteration of the match. Based on 1,600 people, approximately half of those people are repeat IMGs who have not been matched.

● (1020)

The Chair: I think Fleur-Ange Lefebvre would like to make a comment as well.

Dr. Fleur-Ange Lefebvre: Some of these international medical graduates should not be considering entering a residency, they should be entering provisional licensure practice. That's where we are now focusing our efforts. However, that is also extremely resource-intensive and capacity-intensive.

The Chair: Thank you.

We'll now go to Monsieur Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you, Madam Chair.

Good morning, everyone.

Some members still have questions about the federal government's role in managing health human resources. Personally, I do not have any more questions. You are quite aware that it is the responsibility of Quebec and the other provinces. Out of the goodness of my heart, I would like to give you my speaking time. Do with it what you please: keep it for yourself, give it to your colleagues or to the witnesses. Consider it a gift from me, either for April Fool's Day or Easter.

Some hon. members: Oh, oh!

[*English*]

The Chair: Well, happy Easter to you too, Monsieur Malo, and what a gift that is. I will be so kind as to give it to Mr. Tilson.

Mr. David Tilson (Dufferin—Caledon, CPC): Thank you, Madam Chair.

I thank Mr. Malo as well for his Easter gift.

I have a question for Dr. Varastehpour. You said some words that I hope I heard wrong, but which I'd like you to clarify. You used the words “some people buy their way”. I'd like to pursue that with you. What did you mean by that?

Dr. Ali Varastehpour: Yes, indeed. What I meant by that is, as Dr. Bowmer just mentioned... First of all, the cost of exams is higher from the time that he remembers, but that's a different issue. You have to take the EE, QE1, and the QE2 to be licensed. You need the EE and QE1 in order to be theoretically, on paper, eligible to apply for residency positions.

However, there are visa students who have bilateral agreements signed between the Government of Canada and their governments. I even know a person who told me he was being supported by his own family. That's what he said. I don't know if that's true or not. They intern at any residency program they pick and choose. The score is not an issue. Language is not an issue. Clinical skills are not an issue. I've met some of them who don't even understand the comments of the physician, the question or the answer. This is a wide-open fact. I'm surprised that you don't know about it.

I wrote to every department chair in Canada, including one in Ottawa. I got the rudest answer from Ottawa. She said they had no positions. I e-mailed again that on their web page I see people from Argentina, Sri Lanka, and India. Is it you don't have positions for IMGs or you don't have positions? For God's sake, you're the director of the residency program in neurology at the University of Ottawa. What kind of answer is that? She e-mailed that we don't have positions for residency, just get out, leave me alone.

I wrote to Quebec and I got a very interesting answer. I got this answer I think from Toronto as well. Are you seeking a funded position, or do you have funds? The translation: Do you have a million dollars in the bank, or do you want to work and get paid?

This is what I'm talking about. It is not that there are no positions. There are plenty of positions, more than the pool of IMGs probably. That's because not all of the IMGs are up to the market; it's a fact. Some need help, some don't know the language, some forgot medicine—I don't know. But there are a lot of intelligent IMGs, more intelligent than I am.

Mr. David Tilson: Well, you're suggesting it's a system of the rich, and if that's the case—

Dr. Ali Varastehpour: It is.

Mr. David Tilson: —how can that be changed?

Dr. Ali Varastehpour: That is very simple: through legislation. Can you do something like this in the United States, in England, in Sweden, in any developed country? Can you do that? No, and I don't know how they do it in Canada. All our advisory members in the Alberta IMG association said not to bring it up. Why? It is because this is money that is given to the department chairs.

For example, say I'm a program director in internal medicine, in neurology, or whatever. I use that money to finance, supposedly, my research. The question is, if my proposal is not worth funding by the Canadian Institutes of Health Research, why in heaven do I have to do research on the soft money, and if I need soft money, why can't I pay it from my own salary and my staff salary?

This is what it is costing us, and this is what a UN expert uses in calling Canada a racist country. Those are not my words. I quoted it, and I gave you the copy, to show that there is a racial bias in this country. That is what she says from her own experience touring Canada.

Was I clear in answering your question?

● (1025)

Mr. David Tilson: I appreciate your elaborating on it. Those are serious allegations. You have explained them to a degree, and we need to pursue that further.

I have another question, to both you, sir, and to Dr. Martin, perhaps.

I heard some testimony in the immigration committee about programs being provided by the federal government to help upgrade foreign doctors coming to this country. This would be in association with the medical associations, because you have to have the medical people onside to do this; it can't just be the federal government. As well, programs were being provided for other professions, such as engineers or what have you—not just doctors, but other professions. The comment was made, or evidence was presented—and I can't remember by whom—that the greatest resistance from the associations was from the medical associations. The most resistance to—

The Chair: Mr. Tilson, we're running out of time, so can you—

Mr. David Tilson: Do you know anything about that?

Dr. Ali Varastehpour: I have heard anecdotally, but I know a lot of physicians, and as a matter of fact we have a lot of support in the Canadian medical community. One of the faculty at the Royal Alexandra Hospital personally told one of my colleagues to talk to the minister. Instead of doing observership, which is ridiculous for you and for me, request one year of internship, and you will know everything. This has been in books in Canada, by the way. This is not new.

In the 1980s you had to do one year of internship and you would be a doctor—end of story—but they removed it. I don't think there is a resistance; they will be very happy to have somebody work for them as a resident.

Mr. David Tilson: Well, that's what we heard in immigration.

Dr. Martin—

The Chair: I'm sorry, Mr. Tilson, but we've gone quite a bit over time.

Ms. Murray, you're next. If you'd like to continue that line of questioning, that would be fine.

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thank you, Madam Chair; I have a different line of questioning.

I appreciate the panel's input here. I have some experience in corporate system re-engineering, so I was struck by the comments from both Dr. Martin and Dr. Bowmer about system re-engineering. What's occurring to me is that the IMGs may not be seen as the patient in this re-engineering. I know that some of the facilities have patient-centred care initiatives to do improvements in the provision of service to patients, but in fact in a way the IMGs are at the centre of this, because if the IMGs are served, then our system is served and Canadian patients are served.

This is very complex and interjurisdictional. There are success stories here and there, and there are pipeline blockages here and there. It's a complex system breakdown. In provincial politics I heard lots about this almost ten years ago, and I'm sure the problem began before that.

Is there a system engineering organization or framework for looking at this as a system design problem, a way to cross jurisdictions and put the IMGs, those humans who are driving taxis and so on, at the centre of it? I'd like an answer to that, and if there isn't, would that be something that you would recommend? And do you have any thoughts about how to do it, or who could do it, or what kind of framework could do it?

Thank you.

● (1030)

The Chair: Go ahead, Ms. Lefebvre.

Dr. Fleur-Ange Lefebvre: Thank you.

While we have national exams and national accreditation for undergraduate, postgraduate, and continuing medical education activities across this country, the move to national standards for registration and licensure is new. That is going to help. That is a re-engineering process.

We have 13 jurisdictions in this country that license physicians in 13 different ways, and they have agreed that we're moving to national standards. Now, it's going to take some time, because there are 13 pieces of legislation that are going to have to be opened up, but they're determined.

May I segue to Monsieur Malo and Monsieur Dufour,

[*Translation*]

and tell them that, nevertheless, Quebec signed the Agreement on Internal Trade, which includes chapter 7 on labour mobility? Furthermore, they signed the Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications. So they are fully participating.

[*English*]

The Chair: Thank you.

Ms. Joyce Murray: Thank you, Madam Lefebvre.

That may be one part of it. Again, that's not the whole system.

Is there anyone who is looking at the whole system? You get a blockage here; you move that, and there's a blockage there. It's a system redesign that I'm hearing is needed.

Dr. Ian Bowmer: I think the federal government has taken some leadership in this role. When a blockage has been identified, there has been funding. An example is the assessment process, which was really run independently by seven regional or provincial jurisdictions, but is now being brought together as one. The national assessment collaboration, which was funded by Health Canada and HRSDC, was an attempt to do this. It came out of the 2004 IMG task force recommendations.

We're still very much piecemeal as far as the remedial activity is concerned. Just to put it into context, the residency programs aren't the only way international medical graduates come into practice in this country. Approximately 1,400 or 1,500, according to the national physician database, enter practice every year. Only half of them enter from residency. The other half enter through provincial programs. Some of them are mentored observerships, while some of them come just straight from the minimum requirement, which is actually the evaluating exam, straight into a practice, with a mentored process.

Each province has a different way of doing this. Standardizing it would be a very useful opportunity, but again it is a resource issue. As Madame Lefebvre pointed out, it involves not only the exams but also this idea of making sure that someone is safe in practice, and therefore having an observed clinical practice. That is perhaps one.

The next step is to try to coordinate this process across the country, because every province is different.

The Chair: Thank you, Dr. Bowmer.

We'll now go to Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair.

There are so many questions and so little time. I'd like to throw the questions out first, if that's okay.

Dr. Bowmer, you mentioned different standards. I was wondering if there are reciprocal recognition movements going on. I know the U.K., Australia, the United States... You mentioned that Canada and the U.S. have joint accreditation. Are we looking at anything that would expedite reciprocal recognition agreements, and if so, who should do it?

I was also going to ask you to comment. Dr. Varastehpour, I noticed you and Madame Lefebvre nodding in disagreement.

Dr. Varastehpour, I was really concerned when you said that money talks here and that people are buying their way into the Canadian system. I was actually hoping that if you have examples, perhaps you could provide them to our committee so that we could understand it a little bit better. I think it's a concern for all of us.

As well, perhaps you could give your viewpoint on the main barriers facing IMGs in having their skills, training, and education recognized in Canada. I get the feeling there's a lot of politics involved here. If there's any leadership that we could take, who should do it?

Dr. Ali Varastehpour: I have a hard time understanding you.

● (1035)

Mr. Colin Carrie: Pardon me?

Dr. Ali Varastehpour: I have a hard time understanding you completely. If you could phrase your question in a limited manner, I could probably answer it.

Mr. Colin Carrie: Okay.

Dr. Ali Varastehpour: I was listening and I had a ballpark understanding of your comments, but...

Mr. Colin Carrie: What are the main barriers facing IMGs in having their skills, training, and education recognized in Canada?

However, I wonder if Dr. Bowmer could start with my first couple of questions. I know I've posed a lot in a limited time.

Thank you.

Dr. Ian Bowmer: There are a number of attempts. The College of Family Physicians—and perhaps it should speak to this—is actually undertaking reciprocal agreements with other countries, where the acceptance of training in that other country would be accepted automatically in ours. The Royal College of Physicians and Surgeons, the other specialty organization for medicine, surgery, etc., is doing exactly the same.

I would point out, though, that because the training is acceptable, it doesn't mean that the qualification will be equivalent. I like to use the example of anesthesia in the U.S. In Canada, we require an anesthesiologist to manage our intensive care units; in the U.S. they do not. So even though we accept their training, we require additional training if an anesthesiologist is going to provide full service in Canada. That's one level.

The other level—and perhaps your Quebec colleagues can talk to this better—is the France-Québec Entente, which is actually a reciprocal arrangement with the regulatory authority in that country. It is an interesting model where Quebec would accept an individual, and Madame Lefebvre can probably explain that better, but it is an example for this committee.

The Chair: Is there anybody else who would like to comment on that issue for Dr. Carrie?

Yes, Madame Lefebvre.

Dr. Fleur-Ange Lefebvre: Yes, just briefly.

We are working with the College of Family Physicians and the Royal College to see about recognizing foreign training. We have something in various jurisdictions called the fairness commissions, however, and that's something that could possibly work counter to this.

Can we look at an IMG from one country differently than an IMG from another country? We're going to try to develop something that is defensible from a human rights perspective, but we do have to work with the fairness commissioners in these jurisdictions where they exist.

Mr. Colin Carrie: Do I have enough time to briefly—

The Chair: You have about a minute.

Mr. Colin Carrie: Madame Lefebvre, could you comment on the statement, “buying their way into the Canadian system” or “money talks here”?

Dr. Fleur-Ange Lefebvre: We see physicians at the time of licensure. How they get into the system, or the access to residency positions, is not a role of the regulatory authorities.

Mr. Colin Carrie: It's not.

Dr. Varastehpour, are you able to comment on the barriers?

Dr. Ali Varastehpour: I would like to make a couple of comments on one point that I forgot to bring up in my presentation.

I heard that in Manitoba there is a very good program. They have their own exam. I'm not sure if my information is up to the mark, but Dr. Martin may be able to supplement it. You take their exams, you pass their exams, you work one year in a rural area—wherever they send you—and then you are a licensed physician. I know persons who are doing orthopedic surgery after that process. People say that Manitoba and Alberta have the best prospects, Manitoba because of that so-called streamlined approach and Alberta because Alberta has more money.

That is one point to remember, because if one province comes up with a better idea, that idea should be promoted. Instead what the regulatory bodies are doing, or whoever is in charge, is creating bogus—I am sorry to use that word—barriers. One of them is the clinical assessment test. As a physician I am willing to volunteer here and ask one of the physicians in the panel to perform a physical examination of the chest on me. I bet that if you brought a second physician from the university, they can fail each other. There are physical examination textbooks that are five pages and others that are 500 pages.

My question is this: if I am a physician and I have a licence and I take a responsibility for treating you as a patient, I can choose to listen to your heart for ten minutes or I can put it on your clothes. This is against the classic teachings of medicine, but how many physicians actually do that? There are lots.

Another example is that they are teaching us to start interviews in a really artificial way, by asking, “Tell me what you feel”, or “Do you have any idea of this disease?” How many times has each of you gone to the doctor and seen that kind of approach? We are forced to do it. Last year almost everyone from Edmonton, except one person, failed this exam.

If you come with something that is important to you, at least provide one month of training on something like ACLS or CPR. Teach it and then examine it. Any physician will tell you that in the United States, basically... There are published articles on sensitivity and specificity of physical examinations. It is next to zero. This is not something I say, and I never promoted it when I was supervising medical students, but that is a different issue.

I just wanted to raise the issue of Manitoba because I forgot to bring it up.

Would you please repeat the last question that you had?

● (1040)

Mr. Colin Carrie: I think I'm out of time.

The Chair: I'm sorry, Dr. Carrie. We're now going to Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: Thank you very much.

I want to go back to Dr. Bowmer's comments, and Carolyn Bennett also raised this issue about the Canadian health human resource strategy back in 2004. It was part of the accord, and that accord is coming to an end.

It seems to me that very little has been done on that strategy. I'd like to know what has been done, if anything. What can we do to get something done before the end of the accord? I'll pose a rhetorical question: isn't that the basis upon which we should address all of these other issues? If we haven't dealt with that national framework approach when it comes to health human resources, how do we proceed on dealing with the question of foreign credentials, lack of doctors in northern and remote communities, inclusion of the aboriginal community, and so on?

You can go first, and then we'll hear from anyone else on this issue.

Dr. Ian Bowmer: Madam Chair, I am here as the CEO of the Medical Council of Canada. I also happen to be the vice-chair of the Health Council of Canada, so I get mixed up sometimes with the data that I am delivering. I can't answer that question from the Medical Council's perspective; I can only answer from a personal perspective.

It seems to me that the health human resource planning aspect has dropped off the agenda, or at least dropped off the national or the pan-Canadian government agenda.

There has been some really successful re-engineering, as was mentioned, without increasing the physician resource. Alberta has good examples. There have been good examples across the country, but they're very patchy, and I think what has been lost in this is the idea that we were supposed to start with a needs-based assessment of the population. We were supposed to have provincial targets, and it was supposed to be driven at a pan-Canadian level. It seems to me that somewhere in the last five years, that has disappeared.

Ms. Judy Wasylycia-Leis: Is there a body in place that is supposed to be doing this work? Is there a federal-provincial committee of deputy ministers? What exists, and what should be kick-started?

Dr. Ian Bowmer: As I understand it , the oversight committee for this is ACHDHR, the advisory committee on health delivery and human resources, and it is a federal-provincial committee. It's the only one of the three committees that were established after the accord that is still surviving, and it is the one that's responsible for health human resource discussions. There are co-chairs there, and perhaps the committee would like to talk to them.

● (1045)

Ms. Judy Wasylycia-Leis: That's not a bad idea, in fact. I think we should consider it. Yes, we should do that.

Does anyone want to add anything?

Dr. Martin, have you been involved in any interprovincial or federal-provincial discussions around a pan-Canadian approach to health human resources in Canada?

Dr. Bruce Martin: I have to say that I have been involved, but those discussions, to use Dr. Bowmer's term, are somewhat patchy. They are programmatic in the regions in which I work; it's not part of a comprehensive system re-engineering. I have active discussions with my colleagues and partners—clinicians or government individuals in our province and in our neighbouring province and territories—but it's not as part of a concerted pan-Canadian approach. That doesn't mean that some of those don't exist; I'm just not a party to them.

Ms. Judy Wasylycia-Leis: Dr. Fleur-Ange Lefebvre, I imagine it would be useful, from the point of view of your federation, to connect with a body that is actively pursuing the broader question of health human resources from a federal-provincial point of view, or am I putting you in an awkward spot?

Dr. Fleur-Ange Lefebvre: Not at all. Before I went to the federation, I worked for the Canadian Medical Association for ten years, and we've been waiting for this for a very long time.

Anything that helps guide the process, that guides the system, and that helps you manage resources that you need to put into the system to make it work is useful.

Are the medical regulatory authorities themselves HHR planners? They are planners only when directed to do so by the minister of health in each jurisdiction. Their job is to ensure that the physicians who are there are qualified to practise medicine.

The Chair: Thank you so much.

Now we'll go to Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you, Madam Chair, and thanks very much to our presenters this morning.

My first question is going to be to Ms. Lefebvre.

In your opening remarks you referred to the chart that outlines the licensed physicians in Canada. Is that the chart you were referring to, the one that compares the numbers of CMGs and IMGs?

Dr. Fleur-Ange Lefebvre: Yes.

Mrs. Patricia Davidson: You made the comment that in some instances the IMGs showed greater increases than the CMGs. Could you elaborate on this chart and on that comment, please?

Dr. Fleur-Ange Lefebvre: I was going to give you the actual calculations, and then we realized that the way people were reporting provisional licences was a bit different from jurisdiction to jurisdiction. However, I did bring something with me from the registrar in Newfoundland and Labrador, Dr. Robert Young.

I can tell you the total number of IMGs who received new licences, both full and provisional, in 2009. I should tell you that in getting full licences, they may have moved from provisional to full, but there were 90 new licensures. Remember, Newfoundland is a smaller jurisdiction, and the total number of licences awarded to graduates of Canadian schools was 49, so there are jurisdictions...

Ontario is the other one. If you do the actual math, as I said, for the provisional licenses in Ontario, the data are pretty solid, but Ontario had a big splash last year. For two years in a row they licensed more international medical graduates—new licences—than they did graduates of Canadian schools.

This move to see this group of physicians as extremely valuable in the Canadian system is very much alive and well. What we want to do is make sure of, within the context of the agreement on internal trade, is that once they're licensed, they're also eligible for mobility. There is a lot of work to be done, but stay tuned.

Mrs. Patricia Davidson: Thank you.

Dr. Varastehpour, in your comments this morning I certainly hear a huge amount of frustration with the system and with the access to the system by the IMGs. Do things change once IMGs are here, or is it a lack of understanding before the immigration process? Where does the discrepancy arise, or what are the expectations before the immigration process?

Dr. Ali Varastehpour: I believe every IMG expects to take some exams. I have never heard any colleague ask why they examine us. I think I'm more qualified to examine the Medical Council of Canada, but that's my personal opinion. I'm an immigrant, and I should abide by the rules. I don't think it is fair. I don't think it is square.

As I mentioned, it favours Canadian students because they collect the questions, and again this is another well-known fact that all of the medical students here know. But the issue is if there were a rule of law, at least we would have had an equal place to compete.

Some provinces allow you to participate in the match, some don't; some places first iteration, some places second iteration. In Alberta it's really strange, they just tell you you have to wait until their own homegrown system does something.

● (1050)

Mrs. Patricia Davidson: But do you know before the immigration process begins?

Dr. Ali Varastehpour: I knew, and I was USMLE-certified. The textbook that people read here says for Canadian qualifying exam and USMLE. That means they're comparing their own exam with USMLE, which is not really a fair comparison. That is a far more difficult exam.

Still, even if it is the same exam, why didn't they put me right into the next step? So passing and not passing the exam is completely irrelevant when it comes to the EE, the evaluating exam. There are people who pass the EE and get a job right away. That is what I'm emphasizing here again and again. I have passed the EE and I can show you one and I have a TOEFL exam and I'm sitting. I don't know, I hope I can make $100 one night if they call me—if.

This is not acceptable. I don't say you hand everything to me on a golden platter, but you see it is being handed over to foreign nationals, and this has not happened in any other country.

The Chair: Madame Lefebvre, I think you wanted to make a comment.

Dr. Fleur-Ange Lefebvre: It's just a general comment to the committee to suggest that you may also benefit from hearing from the College of Family Physicians of Canada. I believe you have heard from them before.

On their programs for context-specific eligibility routes to their certifying exams—and success at their certifying exams leads eventually to a full licence—they are doing some really interesting work.

The Chair: Okay.

Now we'll go to the last questioner, who will be Dr. Duncan.

Ms. Kirsty Duncan: Thank you so much, Madam Chair.

I'm going to ask, with respect, if the answers can be kept short so I can get through this.

I think what we've established is that the medical exams are expensive, that there's a significant gap between the pass rate for IMGs and Canadian grads of about 30%. What assessments have been undertaken to explain the poor pass rate, and has cultural bias been explored?

The Chair: Dr. Bowmer.

Dr. Ian Bowmer: I guess that's directed to me, Madam Chair.

Ms. Kirsty Duncan: With respect, Dr. Bowmer.

Dr. Ian Bowmer: Thank you.

The evaluating examination is created by a panel of Canadian physicians who are practising in Canada at this moment, and the pass is established on what would be expected of a Canadian graduate just entering a residency or entering a program.

So it is a minimal exam. It is also stripped of Canadian context as much as we can. Because these items are written by Canadian-educated physicians, there's obviously a Canadian bias in it, but there is no public health or organizational aspects to that exam.

Ms. Kirsty Duncan: Has cultural bias been looked at?

Dr. Ian Bowmer: The attempt is to reduce the cultural bias, as much as a Canadian writing an examination question can. Obviously, they won't be on the country's perhaps predominant health questions, because there are now our predominant health questions.

There has been some work in terms of web-based sites to help with communication and cultural acceptance. There's one we support, which was developed through the University of Toronto, and it relates to our objectives. So there is an attempt to do this. It's available as a recommendation when you go on our website.

Ms. Kirsty Duncan: I'm wondering if an assessment in the future would look at cultural bias. I appreciate the actions that have been taken, but if there's an actual assessment...

I'm also wondering if IMGs sit on that panel, those who have become doctors.

Dr. Ian Bowmer: The president of the Medical Council of Canada is an IMG.

● (1055)

Ms. Kirsty Duncan: What number of IMGs do we lose after a failure, in terms of how many come through? If we lose people after a failure, you would be able to see the numbers. Is there a gap? How many do we lose, or do they retake it? What's the percentage?

Dr. Ian Bowmer: We have looked at those data. I can certainly provide them to the committee, but I don't have them on me.

Ms. Kirsty Duncan: That would be extremely helpful.

What is the average number of times an IMG takes to pass, depending on geographic location?

Dr. Ian Bowmer: I can show you some data that explicates it, but there is a decreasing number. If you look at it, it's a graph that falls off, and there's certainly a percentage who pass the first time, and then two or three times, and—

Ms. Kirsty Duncan: Can you provide that data as well, please?

Dr. Ian Bowmer: Yes.

Ms. Kirsty Duncan: Are supports available to IMGs in finding alternative health occupations? Do you think this is a role the federal government could help with? Because it seems to me we're losing tremendous expertise.

Dr. Ian Bowmer: I think that was Dr. Varastehpour's point. There really aren't effective bridging programs for physicians who want to find alternate careers. The provincial governments, Ontario, for example, have established a physician assistance program. Manitoba has a physician assistance program. Alternate careers for people who've been out of the system too long is something that perhaps could be addressed by the committee.

Ms. Kirsty Duncan: That's very helpful. Thank you.

What is the average number of times an IMG uses CaRMS before being successful, and how does that compare to Canadian grads?

Mr. Jim Boone: I don't have the data on that, but I'd be glad to share it with the committee. As I said earlier, approximately half the IMGs in each year's match, for the last two or three years, have been returning IMGs—half of the 1,600.

The Chair: Ms. Lefebvre, I think you wanted to make a comment on that as well.

Dr. Fleur-Ange Lefebvre: Just a comment on the counselling when it looks as if medicine may not be a career. That is mentioned in the pan-Canadian framework as a role of the medical regulatory authorities. We suggested that while it's an important function, it's possibly not the role of the medical regulatory authorities.

The Chair: Mr. Boone.

Mr. Jim Boone: Just as a quick point on that, alternate pathways for IMGs, HealthForceOntario hosted a little symposium for 300 or 400 IMGs for the first time last year. Half a dozen or a dozen organizations told them about different paths completely outside of medicine in some cases. It was well attended. It was very well received by both the partner organizations that were participating in it and the IMGs.

The Chair: Thank you, Dr. Duncan.

I would like to thank our witnesses especially. I want to wish you a very happy Easter. I hope you have a lovely weekend. We as a committee very much appreciate your presence here today and your insightful comments.

To the committee, happy Easter to you all. I look forward to seeing you after the break week.

The meeting is adjourned.

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