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Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): I call our committee to order.

Welcome, everybody, to committee. I'm so glad you're here.

There are two things I want to address. First, we accommodated the Afghan committee that is in session right now. We changed to a smaller room at the last minute to make sure the other committee would have room for everybody to get in. I made that decision as a courtesy, so my apologies for such short notice.

The other thing I have to tell you is that due to the weather, people couldn't get here for the H1N1 briefing, but there will be a teleconference tomorrow. So the briefing will be done by phone tomorrow.

As a result, is it the will of the committee to have our guests continue for an hour and a half on their presentations on health human resources? We have them now scheduled from 3:30 to 4:30. Do I have permission to allow them to continue from 3:30 to 5:00?

Is there discussion?

Monsieur Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Madam Chair, as you know, the Subcommittee on Neurological Disease was to meet at 5:30 this evening...

[*English*]

The Chair: Sorry, Monsieur Malo, I couldn't hear half of it.

Go ahead. Thank you.

[*Translation*]

Mr. Luc Malo: The Subcommittee on Neurological Disease was to meet at 5:30 p.m. this afternoon. However, there are votes scheduled in the House.

I wonder if we might use the time allocated to this committee to hold our subcommittee meeting earlier.

[*English*]

The Chair: Absolutely. Are you saying we could have the health human resources witnesses from 3:30 to 4:30, and then our subcommittee meeting from 4:30 until 5:15, when the bells ring?

Is everyone in favour of that?

Some hon. members: Agreed.

The Chair: It's carried. Thank you very much.

Dr. Bennett.

Hon. Carolyn Bennett (St. Paul's, Lib.): Madam Chair, as we have the first snowstorm of the winter, I think this afternoon the decision to not hold the briefing is an extremely bad example.

In fact, we'd said all along that we would be happy to have the briefing phoned in from Colonnade Road. Tomorrow morning is really not acceptable for a lot of us.

The minister happens to be having a media briefing at four o'clock, at exactly the same time, with the officials—meaning, of all the hours of the week, this is the time she has chosen to have her briefing.

The Chair: I'm sorry, there was no translation.

Are you landing planes or trying to tell me something?

A voice: They'd like Carolyn to speak into the microphone.

The Chair: Oh.

You're not loud enough, Dr. Bennett.

Some hon. members: Oh, oh!

The Chair: Go ahead.

Hon. Carolyn Bennett: I would like to suggest that the minister has every other hour of the week to do her media briefings other than when the officials are booked to be here at this meeting from 4:30 to 5:30. This is in virtual contempt of Parliament that there's been this obstruction put to our being able to do our job as we go to the parliamentary break.

This is an unacceptable precedent. As we move into winter, there has to be provision for a proper briefing, even if it's done by telephone.

I mean, why couldn't they do it by telephone at 4:30 today when we're all sitting here, as opposed to tomorrow at 11:30, probably the last day that Parliament sits, when all of our schedules are chockablock with meetings with people who have to meet with us at that time?

I need to register a complaint. I want it fixed by the time we come back.

It is not lost on us that so often the minister's weekly briefing ends up at a time that's completely inconvenient for parliamentarians or others. We are sitting in this committee at a time when we would normally be listening to the minister's press conference.

The Chair: Might I address this?

First of all, the minister has always come to committee when we've requested her to. She has set up briefings on a regular basis to make sure everyone was kept informed.

Hon. Carolyn Bennett: No: your job is not to defend the minister, Madam Chair. Your job is convey to the minister—

The Chair: Dr. Bennett, I will bring this committee to a close if you can't let me speak.

Hon. Carolyn Bennett: But that isn't your job, Madam Chair.

● (1535)

The Chair: I said I will bring it to a close unless I am allowed to speak.

Now, the fact of the matter is that today we have no control over the weather—I am not God—and we have a great deal to do.

The minister wanted to make sure—

Hon. Carolyn Bennett: Madam Chair, my point is that we're going to have weather for the next three months. What are you going to do?

The Chair: Do I have to adjourn committee because you're being rude, Dr. Bennett?

Hon. Carolyn Bennett: I am not being rude.

The Chair: May I finish? I will let you talk. You can talk yourself to sleep today, if you'd like.

I need to tell you that the minister wanted me to say that she would be very happy to have that briefing presented to you tomorrow. She couldn't help the weather. She had no control over whether or not people could be here today.

That's all. I'm the messenger, and this is it.

Dr. Bennett.

Hon. Carolyn Bennett: I want you to be a messenger, and via Dr. Carrie—

The Chair: You have a point of order, Ms. Davidson?

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Yes, Madam Chair.

We have an agenda before us. We have witnesses sitting here who have come out on a horrible day. We have until 4:30 only. I would suggest very strongly that we move ahead with our agenda.

We have certainly heard the concerns of Dr. Bennett. I think we've heard enough of them. You know the message. Why don't we move on?

The Chair: With the will of the committee, can I just move on and have our witnesses present?

Thank you.

Hon. Carolyn Bennett: Madam Chair, would you report back to this committee what will happen in the next three months—

The Chair: Excuse me—

Hon. Carolyn Bennett: —when there are weather concerns for our briefing on Wednesday afternoon?

The Chair: Well, if people can't get here, Dr. Bennett, I'm sorry; unless you go by sleigh and snow dog, I don't know how you'll get them here.

Hon. Carolyn Bennett: Madam Chair, tomorrow the briefing is by telephone. We could have had the briefing by telephone today. That is the point.

The Chair: People are at airports. People are all over.

This is the end of this discussion.

We'll now go on to the witnesses.

Hon. Carolyn Bennett: I want a commitment from the—

The Chair: Welcome to my committee, witnesses.

Hon. Carolyn Bennett: Excuse me, Joyce. We need a commitment that the minister will not schedule her briefings—

The Chair: What I'm going to have you do now is present. We have before us, pursuant to Standing Order—

Hon. Carolyn Bennett: —during the time of this committee.

The Chair: I will not recognize you at all, Dr. Bennett, if you're going to continue with this kind of conduct.

Hon. Carolyn Bennett: You told me I could speak again.

The Chair: You're done.

Pursuant to Standing Order 108(2), study of human health resources, we will start with our witnesses.

The first one is from Alberta International Medical Graduates Association.

I hope I pronounce your name right: Nicodeme Mugisho-Demu, vice-president, Calgary.

How did I do? Was it okay?

Dr. Nicodeme Mugisho-Demu (Vice-President, Calgary, Alberta International Medical Graduates Association): You were close.

Voices: Oh, oh!

The Chair: Great. Welcome.

We also have, from the Federation of Medical Regulatory Authorities of Canada, Fleur-Ange Lefebvre.

Did I do that okay?

Dr. Fleur-Ange Lefebvre (Executive Director and Chief Executive Officer, Federation of Medical Regulatory Authorities of Canada): Close.

The Chair: Thank you.

We also have, from the Medical Council of Canada, Ian Bowmer, executive director; and from the Canadian Resident Matching Service, Sandra Banner, executive director and chief executive officer.

Each organization has five minutes.

If you would be so kind as to give your presentation, we will begin with you, Mr. Nicodeme Mugisho-Demu.

Dr. Nicodeme Mugisho-Demu: Thank you, Your Honour.

As you pointed out, my name is Nicodeme Mugisho-Demu, and I represent the Alberta International Medical Graduates Association. We are a not-for-profit organization that is committed to integrating foreign physicians into the Canadian medical system without compromising current Canadian medical standards. We are, then, a bridge between over 600 foreign physicians in Alberta and the Canadian medical system.

We all agree on the need to integrate foreign physicians into the Canadian medical system, especially at these times, when a Canadian patient may spend hours in the waiting room just for a prescription renewal, while we have foreign physicians doing such jobs as security guards. There is even a well-known person who made a joke, that if a pregnant woman has a choice between calling 9-1-1 and the cab, she should call the cab, because if anything happens down the road, God forbid, the driver can make the delivery: he's a foreign physician.

It might make you laugh, but this is the sad reality.

The question is how do we make sure that we tap into the resource represented by IMGs so that we can make things better for Canadians and for these IMGs? We as an association will be a key player in this process, because we understand the Canadian medical system requirement and the foreign physicians' needs and challenges in this situation.

There are some challenges. The first one is the lack of assessment procedures that take into account IMGs' prior medical experience. We need to have such a procedure, one that will take into account their prior medical experience and how long they've been out of practice as well as provide an upgrading procedure. This will help to integrate these people into the Canadian medical system. I know some organizations are working on this basis, and, as an association, we are working currently on a fast-track assessment research program funded by Citizenship and Immigration Canada. This research program will be completed by March 2010, and we will be more than happy to share the results of the research with the House for its consideration.

Another challenge is the fact that the few programs in existence for foreign physicians are not integrated. These programs don't work together. We have to make sure they work together. I will give you an example of how serious this is.

In Calgary we have the Calgary clinical assistants program, and in Edmonton we have the surgical preceptorship program and the clinical preceptorship program. These are two-year programs. The IMGs work for two years under supervision, undergoing some evaluations that are comparable to those of Canadian graduates. These are great programs, but at the end of the two years, they're just dropped. These programs become bridges to nowhere. If these people have to apply for international medical programs, for example, for their full licensure, there is no consideration whatsoever of that experience. They have to spend the same amount of time in the residency program as if they would if they hadn't gone through that program. This is a waste of time and resources, both for the Canadian medical system and for the IMGs.

One of the solutions, and the most effective one, would be for all the programs to help foreign physicians to be made into university-based programs. That way, there would better coordination of these programs, and the foreign physicians would have the opportunity to get acquainted with their future colleagues, other medical students.

● (1540)

The other problem is a shortage of residency positions. Of course, this is justified by the lack of preceptors, as well as sometimes the finance. But if we consider that most IMGs apply for family practice —this is an area where the shortage is mostly felt—expanding the qualifications to be a preceptor to family physicians in private clinics and rural areas is a solution to this problem. Then they will be able to mentor these foreign physicians. The House could look into some incentives and tax breaks for physicians who are supervising those physicians.

Those are some of the points we have.

We thank you again for listening to us and for giving us this opportunity to talk in front of this great nation.

Thank you.

The Chair: Thank you very much for the insightful comments. It's very useful to our committee.

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

Dr. Fleur-Ange Lefebvre: Madam Chair and committee members, thank you for this opportunity to speak to you today on labour mobility and international medical graduates.

[*Translation*]

I would like to say that I would be happy to answer questions in both official languages.

[*English*]

I am addressing you today on behalf of FMRAC and its 13 members, the provincial and territorial medical regulatory authorities. You may be more familiar with them under the name “College of Physicians and Surgeons of”, and then tack on the name of a province; in Quebec it's Collège des médecins du Québec. They are statutory bodies established by provincial or territorial legislation to serve the public's interest by setting standards of practice and of professional conduct and by determining the qualifications for licensure and for maintenance of licensure.

You will have before you a copy of the latest draft of the FMRAC Agreement on National Standards for Medical Registration in Canada, dated October 21, 2009. And since it's out for consultation with our members, and hopefully approval by their respective councils, there will be a few more changes, but these are not expected to be substantive.

When the recent changes to chapter 7, on labour mobility, of the Agreement on Internal Trade came, medical regulators were already developing national standards for registration of physicians. The timelines have been somewhat accelerated as a result of the need to come into compliance with the AIT. This, while not always a bad thing, does present some challenges.

Since the AIT mandates that no extra requirements can be made of physicians who already hold a licence to practise in a Canadian jurisdiction and who want to move to another jurisdiction within the country, standardization will in fact enhance labour mobility. When we are done, most likely by the end of summer 2010, all medical regulatory authorities in Canada will approach licensure in the same way.

The need for definitions in our document that I've shown you cannot be overemphasized. I have to show you another document. My president didn't want me to do this, but I'd already printed it so I told him I would anyway. This is a 76-page document that we developed last spring, entitled "Inventory of Medical Licensure Terminology in Canada: Definitions, Descriptions, Conditions and Provisions". It describes more than 125 different categories of licensure, both full and provisional. It has served to highlight the degree of variability across the country and has galvanized FMRAC and its members towards standardization.

There has long been a "gold" standard for physician training in Canada that leads to a full licence in every jurisdiction. We are proposing to now call it the "Canadian" standard.

This agreement, among all medical 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 will initially be eligible for a provisional licence. Section three, on pages 5 and 6 of your document, outlines the conditions that must be met prior to the issuance of a provisional licence.

Section four addresses how a physician can move from a provisional to a full licence. Details about the assessment of competence and the types of restrictions that will apply to a provisional licence are part of the ongoing work of the medical regulatory authorities under the coordination of the FMRAC.

I cannot stress this enough. The intent is for every medical regulatory authority across the country to apply the same categories and definitions for full and provisional licences, to require the same conditions prior to initial licensure, and to require the same conditions for any subsequent change to the status of a physician's licence.

A nationwide agreement on what constitutes a full and a provisional licence will achieve the goal of the AIT. Even physicians with provisional licences will have enhanced mobility if every jurisdiction uses the same categories, assuming the receiving jurisdiction has the resources for the supervision requirements and other conditions that may exist as part of that provisional licence.

The work we are doing to standardize licensure processes also assists in standardizing foreign credentials recognition.

Medical regulators in this country can already proudly point to foreign credential recognition taking a matter of a few weeks—much less time than the one year prescribed in the recently announced pan-Canadian framework that we heard about last week. Our members have worked and continue to work tirelessly to help IMGs become licensed and find training and work in health care. In fact, in recent times, in several provinces, the majority of new physicians registered have been international medical graduates.

Provincial and federal departments of labour and of health are very aware of the intensity with which medical regulators across Canada are developing a renewed national standard for physician registration, one that includes a common approach to the recognition and licensure of IMGs, as well as to the output of our Canadian system.

Medical regulatory authorities are tasked by governments to ensure that 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.

● (1545)

Thank you. We would be pleased to answer any questions.

● (1550)

The Chair: Thank you so very much.

We'll now go to the Medical Council of Canada, with Mr. Ian Bowmer, executive director.

Dr. Ian Bowmer (Executive Director, Medical Council of Canada): Thank you, Madam Chair and members of the committee, for the opportunity to present on behalf of the Medical Council of Canada.

The Medical Council was founded by Parliament in 1912 to establish an acceptable national qualification for the practise of medicine in Canada. Every graduate from Canadian medical schools takes our examinations prior to entering clinical practice, and almost all international medical graduates must complete one or more Medical Council examinations to be eligible for Iicensure.

Every year, 12,000 candidates take Medical Council of Canada examinations, which assess basic medical knowledge, clinical skills, and professional behaviours. After passing our final examination and meeting all other credential requirements, the candidate is awarded the licentiate of the Medical Council. This is one of the requirements that provincial and territorial regulators require before issuing a physician a licence to practise.

The council has taken the lead on several successful collaborations with the Government of Canada—through Human Resources and Skills Development Canada and Health Canada—as well as partner medical organizations. We've worked together on measures to enhance the integration of international medical graduates, IMGs.

One such collaboration resulted in the launch of the Physician Credentials Registry of Canada.

The Medical Council and the Federation of Medical Regulatory Authorities of Canada received funding through HRSDC to develop a national repository of verified physicians' credentials.

The Medical Council has been operating this service since July 2007, and we now process about 380 candidates per month. Physicians can submit their documents prior to immigrating to Canada. IMGs applying to more than one jurisdiction can choose to share their verified credentials with multiple organizations at once through the repository, saving time and effort.

While the time for verification depends on the source institution abroad and the type of document, the average is from 81 days for a medical degree to 108 days for verification of postgraduate training. This repository is currently available only to international medical graduates, but we will be expanding it to Canadian physicians shortly.

Opening an account with the registry and sending certified copies of relevant documents is the first step that an IMG can take before coming to Canada. A second step is to take the Medical Council's evaluating examination.

Since 1979, at the federal government's request, the Medical Council has been providing the evaluating exam as a screening mechanism. Since 2008, we have delivered this assessment through a computer-based examination now available at 500 sites in over 70 countries around the world and offered six times a year. It has always been intended for international medical graduates prior to their immigration to Canada. However, at the present time, only 50% of those taking it do so from outside Canada.

Our data show that if a candidate fails this examination one or more times, they have a low probability, less than 35%, of completing the licensing process. We believe the federal government would benefit—

The Chair: I am so sorry to interrupt you, but the bells are ringing and we're being summoned back into the House of Commons. If you will be patient, we will be right back to listen to the rest of your presentation.

Committee, I'm sorry, we all have to go to vote.

Thank you.

● _____ (Pause) _____

●

● (1640)

The Chair: Ladies and gentlemen, I know we don't have a complete committee here as of yet, but we will soon.

We need to make some decisions. On paper we have said that we were going to go to neurological disorders, I believe, at 5 o'clock.

Right now, do I have permission for the witnesses to continue...?

The Clerk of the Committee (Ms. Christine Holke David): We need quorum in order to make a decision. We have seven, a reduced quorum; we can listen to witnesses.

The Chair: We can finish listening to witnesses then.

The Clerk: Yes, exactly.

The Chair: Why don't we do that. After that, hopefully the quorum will be here.

Dr. Bowmer, could you continue, please?

Mr. Ian Bowmer: Madam Chair, thank you.

I had covered one of the areas, which was the repository. I was about to tell you about the second step that an international medical graduate can take before coming into Canada, which is the Medical Council's evaluating examination.

Since 2008 we have gone to a computer-based examination, which is now delivered in 500 sites in over 70 countries and offered six times a year. The important part about this examination is that we do know from our data that those candidates who fail the examination one or more times have a low probability of actually completing the licensing process. We believe the federal government would benefit by requiring potential licensure applicants to provide evaluating examination results for consideration with immigration applications.

A third successful joint project has been the development of a national assessment collaboration. This collaboration is in response to recommendation 2b in the Health Canada-supported IMG task force report of 2004. The national assessment collaboration is a partnership of national medical organizations; provincial and territorial governments; provincial, international, and medical graduate assessment programs; and Health Canada. We now have established the ability to deliver a single, new, nationally recognized clinical examination to assess international medical graduates applying for residency positions. A governance structure has been negotiated and will reside within the Medical Council. The examination is centrally coordinated but delivered regionally through the seven existing international medical graduate assessment programs. Three centres are now participating in a proof of concept for 2010.

Fourth is the council's collaboration with the Federation of Medical Regulatory Authorities and the individual regulatory authorities on an application to HRSDC for funding under the foreign credentials recognition program. Building on the success of the physician credentials registry, we plan to develop a web-based national registration process. This will provide international medical graduates, and in fact all physicians, with a single portal where an application to any of the 13 regulatory jurisdictions can be electronically populated from the existing document repository.

We look forward to continuing these collaborative efforts, which I am convinced will provide a fairer and more transparent licensing process for all physicians in Canada and improve the integration of international medical graduates into the Canadian medical system.

Thank you.

● (1645)

The Chair: Thank you very much.

I want to say a special thank you to you for your patience during the votes. We are going to have the bells ring again at 5:15, and my apologies for that, but we have to go vote.

Having said that, I now need permission of the committee to go into questioning because we had decided previously we were going to do something else.

Pardon me?

Hon. Carolyn Bennett: We have another witness.

The Chair: I'm so sorry, my apologies.

I'm really trying to make sure everyone gets on.

Okay, Canadian Resident Matching Service, Dr. Sandra Banner.

Go ahead.

Ms. Sandra Banner (Executive Director and Chief Executive Officer, Canadian Resident Matching Service): Thank you for the opportunity to present the work of the Canadian Resident Matching Service to the Standing Committee on Health.

The Canadian Resident Matching Service is the access point to postgraduate medical education in Canada. All applicants, whether they're internationally trained or Canadian trained, must enter at the first level, which is PTY1, and CaRMS is the doorway into that process. It's an electronic application process, it's a matching service, and, of course, it's a data repository.

We've been serving the needs of international medical graduates for as long as the organization has existed, which is since 1970. We're not-for-profit. We really sit in the middle of the medical education community.

The goal of the electronic application and matching service is to have a completely transparent, fair, and accessible system. It is often misunderstood, but the Association of Faculties of Medicine of Canada sets the criteria for ranking in our selection system, not the match itself. The match only offers the process.

Since 2006, when the Association of Faculties of Medicine changed their policy and opened up the matching and selection process to international medical graduates, we have been able to witness an incredible increase in the number of international medical graduates who are attempting to enter the postgraduate medical education system in Canada. I'll give you an example.

In 2003, there were approximately 600 internationally trained medical graduates who would register every year for an opportunity to have access to our postgraduate system, but after the change in policy, we now see between 1,600 and 2,000 who register each year to be matched somewhere in Canada for postgraduate training. I think these numbers will mean something to you and have some consistency, and I think we can begin to depend on them.

Since 2008, CaRMS has sponsored an annual international medical graduate information symposium. We partner with other sister medical organizations, and with the assistance from the Ministry of Health in Ontario, we have been able to offer workshops and seminars to more than 400 international medical graduates to try to help them understand the system, the timing, and how to negotiate entering medicine in Canada. Feedback from both internationally trained physicians and workshop organizers reinforces how valuable this symposium has been to all attendees.

Since 2000, CaRMS has also identified a subset of international medical graduates, who are Canadians studying abroad. We define them as Canadian citizens or permanent residents who were legally in Canada prior to getting a medical education, whereas international medical graduates have traditionally been people who became Canadian citizens or landed immigrants after obtaining a medical education somewhere in the world. We see this other subset as those who started out with Canadian status, and then went abroad to get a medical education. Through a grant from Health Canada we have been researching this particular group of Canadian students who elect to study medicine in more than 25 countries around the world.

Now I want to go back to numbers, if I may. As I told you, since 2006 we have seen a consistent number of international medical graduates registering each year, consistent at somewhere between 1,600 and 2,000, but about 50% of that number are those who have been coming back each year. They were not successful the year before, or the year before that, so they're recycling, in a way, through the matching process, and 50% are new to the system each year. Again, that number is now quite consistent. So about 800 each year have never been in the match before, have just written their exams, and are new in attempting to enter the postgraduate system.

There's a final piece of information I want to share with you. In 2008, this group of Canadians studying abroad represented 24% of this new cohort; in 2009, they were 31% of this new cohort; and this year, because we're now in the match of 2010, they are as high as 40% of new internationally trained medical graduates entering or attempting to enter our system.

● (1650)

This subset of international medical graduates is a growing proportion of the international medical graduates who are attempting to attain licensure in Canada.

The Chair: Thank you so very much.

Now I need to ask if it's the will of the committee to go into questions. We were going to go into something else, but do I have the will of the committee to continue on with that?

Some hon. members: Agreed.

The Chair: Okay, we'll do that now.

Also, we were going to get into the topic of neurological disorders a little later, but we're going to have bells at 5:15, and there are only two issues we have to deal with, so....

I would suggest that has to do with family day. Those dates—February 15 and 16—will not work, so I suggest we deal with that when we come back after break.

Is that okay with everybody?

Some hon. members: Agreed.

The Chair: Thank you.

We'll now go to questions and answers....

Did you want to say something?

Mr. Patrick Brown (Barrie, CPC): We could probably talk about it briefly at the end of this meeting. It would take only five minutes.

The Chair: If the bells ring, I have to get back. We have 15 minutes only.

Mr. Luc Malo: So 5:10.

The Chair: Okay, then, we'll stop at 5:10? Let's do that.

Let's start with Ms. Murray.

Ms. Joyce Murray (Vancouver Quadra, Lib.): Madam Chair, I'll be sharing my time with Dr. Bennett.

The Chair: Okay.

Hon. Carolyn Bennett: Or do you want us to do five minutes each?

The Chair: Five minutes each, please.

Thank you.

Ms. Joyce Murray: Thank you.

Thanks for the testimony and the encouraging remarks as to progress that's been made. I was part of a provincial government back in 2000 and 2001 that was dealing with the impacts of not having enough doctors and the frustrations around foreign-trained doctors. This is, as we know, a long-time challenge. It's heartening that there's progress, but there's still clearly lots more to be done.

I have a couple of examples of why I'm still mystified about the complexity for international medical graduates. On the one hand, I have a colleague who's a doctor and sits in this House, who described going to Australia, paying a $100 registration fee, and being able to practise the next day. That makes sense to me.

My other real-life example is a son who married a woman from the EU who had completed her medical training and actually later became top in her country. But when she came to Canada following her training and prior to doing a residency, she heard so many horror stories about how long it was going to take for her to get into the queue and complete her training and about the possibility that she would never get to be a doctor in Canada that she went back to her home country in Europe, and that was the end of the marriage.

I see both sides—both the possibility of solutions, but also that we're not there yet.

I'd be interested in just one comment from each of you. If you could have one thing recommended by this committee in terms of our health human resources study with respect to this issue, what would that be?

● (1655)

The Chair: Keep in mind that you have a very short time to answer, because Dr. Bennett is sharing the time.

Who would like to answer that?

Go ahead.

Dr. Fleur-Ange Lefebvre: Thank you.

There are roadblocks, and they're roadblocks because of resources. One of the big resource requirements is assessment. It's a roadblock for funding and it's a roadblock for faculty. We have increased the undergraduate enrolment, so they are busy dealing with new trainees, with increases in numbers that we've never seen before.

So it's the capacity issue: we can't keep telling you that enough.

Dr. Ian Bowmer: I'd just add that the reason for the clear flow to Australia is that Australia actually acknowledges our assessment process. One of the things that perhaps need to happen is this mutual recognition of assessment processes. We had been working with Australia for a while. They've just changed their whole process around. In terms of the recognition of a competent assessment authority, I think everybody recognizes that the qualifications are not the same from country to country, but the assessments can be standardized, and that's something we could work on.

The Chair: Go ahead.

Ms. Sandra Banner: I think we must recognize that we have a cohort of internationally trained physicians that is somewhat predictable, and we need some predictable funding to allow both assessment and training to follow. We are an immigration-based country. This should not be a surprise to any of us that the source of some of our physicians will be through immigration, and we must have set aside in every section a dependable source of funding for training.

The Chair: There's one minute left.

Do you want to go right ahead?

Dr. Nicodeme Mugisho-Demu: Yes.

Dr. Bowmer was right about the need to have that mutual recognition, and if in that case Australia was able to take the Canadian physician, it's because they have that mutual recognition.

That could be done as well. Canada could look into where we get most of the IMGs coming from, what country that is, and, based on those statistics, they can go over there. There could be investigations to see what the educational systems in those countries are and to have some kind of recognition or upgrading of that education system to have people coming in knowing what they're capable of or not.

The Chair: Thank you.

Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Thank you, Madam Chair.

I want to thank the witnesses for being here this afternoon.

Mr. Mugisho-Demu, I would ask you to explain whether... In your statement, you indicated to us that some programs were currently underway in the province of Alberta, your province, but that these programs led nowhere and that students enrolled in them were unable to find ways to be included in the medical system, the area in which they would like to practice.

Have you indicated these problems to officials at the Alberta Department of Health, for example? Have you provided any solutions? These are the preliminary questions that I have for you following your testimony.

● (1700)

Dr. Nicodeme Mugisho-Demu: Thank you, sir.

Earlier, I indicated that we had a problem ensuring program or project integration. Last July, we appeared before the legislative assembly in Edmonton. We had raised this problem at the legislature, and we explained that these programs were provided on an individual basis. They are not connected to any university.

So, when these people complete their two years, the funding ends and it leads nowhere. If this project was tied to a university, such as the University of Calgary or the University of Alberta, for example, there would be better communication about the program, to the extent that we could integrate the experience the students gained over these two years. Two years is a really long time, and if these people were able to benefit from that experience to reduce the amount of time that they have to spend in residency programs, it would be a good way of reducing costs and time, and this would help both foreign doctors and the Canadian health care system.

Mr. Luc Malo: Could you tell us about your own experience?

Dr. Nicodeme Mugisho-Demu: Thank you for that question.

I arrived in Canada as a refugee as a result of problems that I had experienced in my country. I needed to find a job. I was receiving assistance, but I didn't like that. I started to work as a security officer for G4S. It was really depressing, until I found a job as a medical receptionist. The doors opened even wider when I began a program and started working under the supervision of doctors. This helped me a great deal.

As a result of those experiences, I lost the passion and interest I had in medicine. As a doctor, that wasn't what I had planned for myself. I lost my passion, but I thought that I could help other foreign doctors as a result of my experience. Working with doctors in Alberta would benefit them. I started my company, Blue Sky Staffing Network, to help foreign doctors communicate with private clinics. That is what I am doing now, and I hope to get help to do this. I work hard for the association that I am representing today, in order to ensure that we speak with one voice and help foreign doctors become part of the Canadian system.

Mr. Luc Malo: My time is up? Very well.

Thank you very much.

[*English*]

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

Ms. Wasylycia-Leis.

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

Thanks to all of you for your patience as we run back and forth for votes.

I would like to begin by asking the question about the fact that physicians have been given the later timetable under the government's new framework document—I don't know why that is, exactly—and whether or not physicians couldn't have been included in the list of those to receive the information about their training within the year.

Dr. Fleur-Ange Lefebvre: If I may, we were surprised when the announcement came through as well. The way that Minister Kenney was portrayed in the media...he said that doctors had refused to come to the table, or implied that doctors had refused to come to the table. We quickly got onto the system and said, "What table didn't we come to?" And apparently, that's not quite what was said.

We're actually pretty proud; we're ahead of the curve on this one. We think the confusion may stem from a request that we made to the Forum of Labour Market Ministers asking for an extension to the implementation deadline that was originally April 1, 2009, when it comes to implementing the agreement on internal trade.

We had asked for a two-year extension, and we think that is where the confusion started to arise. We know we're most likely not going to be granted that deadline. But as we're working on the AIT, we're working on foreign credential recognition at the same time, so we think we'll be ready before then.

● (1705)

Ms. Judy Wasylycia-Leis: Are you saying that physicians could now be added to the list of those that will be processed starting in 2010?

Dr. Fleur-Ange Lefebvre: The quick survey I did of our members when the announcement of the pan-Canadian framework came out indicated that most of them already provide an answer to an IMG before a year. And that's what it is, right? It's not that after a year you're licensed; it's that after a year you know what your chances are of achieving licensure.

We're already ahead of that year deadline, so we're already there.

Ms. Judy Wasylycia-Leis: In effect, it's proceeding regardless of the deadline set out in the government framework document?

Dr. Fleur-Ange Lefebvre: We are proceeding in compliance with the agreement on internal trade, which will place us ahead of the pan-Canadian framework.

Ms. Judy Wasylycia-Leis: Okay.

We know there is a shortfall, they say, of about four million to five million Canadians without a family doctor. How many physicians-in-waiting are there from foreign countries in Canada today? Does anybody know?

As well, to what extent can we help meet the demand in Canada if we fix the problem of foreign credential recognition?

Ms. Sandra Banner: As I indicated, CaRMS is the only route in—aside from a program in Alberta, but the same people who apply to Alberta apply to CaRMS, so we have that count. We have, as I said, approximately 1,600 who declare themselves to have written the exams and to be ready to begin postgraduate training. That number has been consistent since 2007: 800 of those are recycling and about 800 are new.

The opportunities for those 1,600.... Last year we had close to 500 who entered postgraduate training, of those 1,600. This year, from the numbers we see coming back from the provinces, that will be down slightly. There seem to be fewer opportunities available to international medical graduates this year than in the previous year. We're looking at possibly a 4:1 ratio of the number of positions available and the number of internationally trained physicians who are competing for those positions.

Dr. Ian Bowmer: Chair, perhaps I can add to that.

The committee is probably aware that, unlike the United States, where every international medical graduate has to go through a residency program, about half of the physicians, international medical graduates, entering practice every year go directly into practice without going through a residency program, and about half of them entering go through a residency program. A number of physicians in the community have never gone through a Canadian residency program because they've been assessed by the regulatory authorities on the basis of examination and credentials that they are ready to go into practice. Whether that's supervised or independent practice is another question.

The sole source is not just the residency program, but the residency programs across this country are really the way to do the standardized assessment.

The Chair: Thank you, Dr. Bowmer.

We'll now go to Mr. Brown.

Mr. Patrick Brown: Thank you, Madam Chairman.

You said, in response to Judy Wasylycia-Leis, that the number who have passed the exams was 1,600. Do we have any idea of the number who have not written the exams?

I know doctors in my community who can't afford to spend the few thousand dollars to write the exam. Do we have any sense of what those numbers would be across the country?

Why is it so much easier to become integrated into the system in Saskatchewan and Manitoba compared with where I come from in Ontario? We saw percentages at one point in this committee, and the differences between those two provinces and Ontario were quite stark. What would it take to increase that residency?

You talked about capacity issues. What would it take to increase the residency spots to have a better than 4:1 ratio, and where does that responsibility lie?

Dr. Ian Bowmer: I can give you some numbers, Madam Chair.

At present, about 4,000 people a year are coming through the physician repository. Don't hold me to that exact number, but it's about 4,000. Over the last few years, the number of people writing the Medical Council's evaluating exam, which is the requirement for entering into residency and the minimal requirement for entry into practice, has been dropping off. In previous years, about 3,500 candidates wrote the exam. In 2008, this dropped to 2,800; and in 2009, it dropped a little more.

The numbers are going down from the international medical community. That's the numbers game.

● (1710)

The Chair: Thank you, Dr. Bowmer.

Dr. Fleur-Ange Lefebvre: We have jurisdictions that have a high reliance on IMGs—Saskatchewan and Newfoundland predominantly, and Manitoba also. But for the past two years, Ontario has licensed more IMGs than the outputs of Canadian schools. It's a high-stakes profession. The consequence of error is high, so we can't take chances. That's why the assessment is critical.

The Chair: Thank you so very much.

I want to thank the witnesses for their patience today and for coming out in this inclement weather.

Before you go, I want to tell everybody that we have on our committee Dr. Kirsty Duncan, who has just won an award for pandemic preparedness from the Chamber of Commerce of India. We're very pleased about that.

Congratulations, Dr. Duncan.

Voices: Hear, hear!

The Chair: We'll now go in camera.

Could I ask everyone to leave except for the committee on neurological disorders?

Thank you.

[*Proceedings continue in camera*]

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