FOREIGN TRAINED DOCTORS IN ONTARIO – A REVIEW OF THE PROCESS, IT'S EFFECTIVENESS, EFFICIENCY, AND LEGITMACY

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FOREIGN TRAINED DOCTORS IN ONTARIO – A REVIEW OF THE PROCESS, ITS EFFECTIVENESS, EFFICIENCY, LEGITIMACY AND FUNDAMENTAL FLAWS

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ABSTRACT

With the level of difficulty a foreign trained doctor must endure to achieve doctor status in Ontario, there is an apparent flaw in the system that this paper suggests may be a result of institutional racism. The process for foreign trained doctors to undergo is examined in the context of the doctor shortage in Ontario, the assessment process, and case studies from other countries that suggest the difficulty foreign trained doctors experience may be a result of institutional racism. This paper argues that foreign-trained doctors are important to physician resource planning in Ontario and there needs to be reform of the current licensing requirements to recognize their credentials.

Key Words:

Foreign-trained doctors; institutional racism; Ontario; assessment process

Dedicated to my mum, dad and brother
for believing in me and guiding me through the
happiest times and the roughest storms.

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Introduction

In 2007, the UN ranked Canada the fourth best country in the world to live in. Canada is a country known for its varying landscapes, abundance in natural resources and diverse population in differing occupations. It is also seen as a second chance to fulfill an individual's dream of achieving her/his full potential as a community member. For many aspiring doctors from abroad, Canada is viewed as a land of hope for a better life. Foreign-trained doctors want a place where they will be able to put their skills and education into practice toward the general good of the community while aiding their own livelihood. In an era where globalization has removed many of the barriers to trade in goods and services, it is apparent that bringing human capital to a new country is thought to be welcome. But upon arrival into a new country, the idea of being welcomed is experienced differently by immigrants from different countries. One of the places affected by this global phenomenon and migration of people from all around the world is the province of Ontario.

Data from the 2006 Census reveal that Ontario has the highest percentage of people born outside the country. In that year 3 million (or 26.8 percent of the population) was born outside the province (Statistics Canada, 2006). At the same time, statistics also show that 540,000 foreign-trained immigrants were either unemployed or under-employed, representing a $5 to $7 billion dollar loss to the overall Canadian economy (Health Canada, 2004, p.7). The issue of foreign-trained doctors in Ontario is one met with a lot questions and concerns from the doctors, medical groups, the government, and the general public. Some view the retention of foreign-trained doctors as a solution to the problem of the doctor shortage in the province, while others believe that the supply of doctors should be limited to the resources available in the province

because having foreign doctors would be more costly and would further restrict job opportunities of the current population (Evans, 1976, p.148), or more importantly, those Canadian-born and educated in Canada. The issue of foreign-trained doctors is also impacted by the fact that there are many stakeholders involved, including regulatory bodies, universities and training institutions, related provincial and federal ministries, community district health councils, community health centers, hospitals, and international physicians (Bennett, 2001, p.2). With these stakeholders involved, there is research that suggests that the marginalization of foreign-trained doctors in the province is "a systematic effort to reserve the upper segments of the labour market for Canadian-born workers" (Bauder, 2003, p.708).

Since the mid 1980s, many policy decisions regarding the development of physician resources have been heavily influenced by the Barer Stoddart Report, which predicted an over supply of physicians across the country (Bennett, 2001, p.15). Responses to this report ranged from suggestions to streamlining foreign-trained physicians' access licensure to decreasing of postgraduate training positions and entrance in medical schools. The Royal College of Physicians and Surgeons of Ontario (RCPSC) also discontinued the recognition of postgraduate training programs outside Canada and the US in 1997 (Bennett, 2001, p.1). At the same time, data indicated that 25.5 percent of active physicians were foreign-trained and 46 percent of them were family physicians (Nasmith, 2000, p.1). However, because of the system currently in place, many foreign-trained doctors find it difficult to have their credentials recognized in Ontario. This raises another issue that is addressed by some scholars in the area of medicine; systemic and institutional racism (Carroll in Foster, 2008, p.10). For these reasons it is worth examining the issues surrounding the topic to come to a better understanding of what it takes for a foreign-trained doctor to become a practicing physician in Ontario. This paper will argue that foreign-

trained doctors are important to physician resource planning in Ontario and there needs to be reform of the current licensing requirements to recognize their credentials in the province.

This paper will be divided into six parts. Part One of the paper will present a demographic overview of Ontario, examining the differing trends across the province from rural communities to the larger cities. It will also examine the doctor-to-patient ratio and discuss the general shortage of doctors in certain geographical areas in Ontario. It will then review reports that call for more doctors in the province, specifically, foreign-trained doctors. The main question addressed in this section after looking at the demographic overview is: *Where are the foreign-trained doctors?*

Part Two of the paper will look at the current rules and regulations that foreign-trained doctors need to fulfill in the accreditation process in order to become licensed practicing doctors in Ontario. It will discuss the application process as well as a general time-line of how long the average foreign-trained doctor will have to undergo the accreditation process before being able to practice in the province. This section will seek to answer the questions: *Why is it necessary to seriously consider licensing foreign-trained doctors in Ontario? And what is the importance of their role in the province?*

Part Three of the paper will address how the restrictions on foreign-trained physicians ultimately affect many of the communities in their need for doctors. It will also briefly look at how the accreditation process affects other foreign-trained professionals wishing to practice in the province. The main questions to be answered in this section are: *What and where are the barriers for foreign-trained doctors in the current licensure process? How does the assessment process and overarching theme of systemic racism contribute to the success or delays faced by foreign-trained doctors as they go through the licensing process?*

Part Four of the paper will look at how other provinces have dealt with foreign-trained doctors and whether using them as examples for Ontario to look upon are warranted or not. The provinces this section will look at are Newfoundland and Labrador, British Columbia, and Quebec.

Part Five will address the varying recommendations to the issue as put forth by members of the medical community, provincial government and organizations representing foreign-trained doctors. This section will seek to answer the following questions after these recommendations have been presented: *Are the proposed recommendations valid? And will they solve the on-going problem with foreign-trained doctors unable to practice in Ontario?*

The conclusion of the paper will tie together the elements discussed in the paper and will look at the future of foreign-trained doctors in Ontario in relation to what researchers and scholars believe will occur given the current immigration trends, assessment, and time constraints. The conclusion will address the question; W*hat changed need to be made in the current licensure process?*

Purpose and Methodology

The purpose of this paper is to examine the accreditation process for foreign trained doctors and discuss if the current rules applicable to this category of professionals are effective and efficient from the views of medical professionals and groups representing foreign-trained doctors. The assessment process will be looked at through the theory of institutional racism examined by Edington, Foster and Bauder, who suggest that it has been a part of medicine for decades and continues to persist. It is evident in the doctor selection process between graduates from Canadian medical institutions versus doctors who hold medical education and experience

from foreign institutions that racism is a reasonable – thought not necessarily the only possible – explanation for the current situation, as will be explored in this paper.

The issue of a need for more doctors in Ontario will be examined under the context of the current situation in Ontario using measurements of the doctor-to-patient ratio, current and projected demographics as well as the distribution of medical resources across the province. An environmental scan assessment, which will include data collected from the 2006 Census and statistics including information of the number of doctors in the province and their distribution, will be used here to lay out the current status of the province.

The paper will look at the issue of foreign-trained doctors in light of the different perspectives, provided by members of the associations representing foreign-trained doctors, provincial government representatives, members of the medical community as well as scholars, and will address the question of whether this is a problem concerning an inefficient use of domestic medical resources, or whether the problem is surrounding foreign-trained doctors and the ineffective system of accreditation they must undergo in order to be practicing doctors in the province. It will also bring forth the issue of systemic racism that may be a reason why it is becoming more and more difficult for foreign-trained doctors to achieve their status in the Ontario medical community. This question will be addressed through examining the works by experts found in the Canadian Medical Association Journal, works published by the Association of International Physicians and Surgeons of Ontario, Health Canada publications, and works commissioned by the College of Physicians and Surgeons of Ontario. This paper will also look at the calls for change in the process and discuss the probable solutions to the problem as put forth by these same organizations.

Institutional Racism in the Medical Field

Before this paper can address the demographic trends of Ontario, it is important to look at the overarching theme of institutional racism. Although foreign trained doctors may experience other institutional barriers to licensure in the province, this paper suggests that one of the biggest barriers is due to institutional racism found in the medical field. Institutional racism in medicine is an area, although not proven, that is important to keep in mind when looking at the long accreditation process as well as the low percentage of foreign-trained doctors actually becoming qualified doctors in Ontario. Since the formation of medical societies that decide who can and who cannot become a doctor, a lot of skepticism in these institutions has been raised about their actual role and values in the decision-making process. As Edginton commented on the forming of medical societies: "Its motive in restricting entry to the practice of medicine was not to protect the health of the population (by eliminating quacks), but to create a medical monopoly" (Foster, 2008, p.7).

Foreign-trained doctors, or "immigrant doctors of colour" rather, continue to be colonized and subjected to a "secondary imperialism" in the political economy of medicine (Carroll in Foster, 2008, p.10). Foster also notes that the difficulties immigrants of colour encounter in the recognition of their foreign credentials can be understood as a systemic process of labour-market exclusion, facilitating the maintenance of a "Whitestream" economics and practice (Foster, 2008, p.10). As will be shown later in the paper via the example of "immigrant doctors of colour" in the United Kingdom and the racism experienced by them in the medical field, it is suggested that the problems surrounding licensure and maintaining licensure may be caused by similar reasons in the Ontario experience. Thus the monopoly over medicine is affected through the ability to utilize and define entry requirements into the practice, and the

performance measures of success. Bauder argues that the Medical Council of Canada and other medical regulatory authorities in the provinces attempt to reproduce the social competency and cultural integrity of the medical profession by requiring foreign-trained doctors to internalize cultural competency standards specific to the profession as it is practiced by Canadian-born and Canadian-trained applicants (Bauder in Foster, 2008, p.11). Foster goes on to say that "credentialism and licensing procedures can therefore facilitate the cultural exclusion of immigrant practitioners, circumscribe their identity as high-risk interlopers, and trivialize their skills and potential contributions to society, all without any reference to race" (Foster, 2008, p.11). Through a certification and recognition of credentials system, the medical-regulating body can then enforce the reproduction of themselves through the differential treatment between foreign-trained doctors and mainstream Canadian-educated workers.

Part One: Ontario and its Doctors Today

This paper will now look at the demographics and current trends of the province of Ontario in the midst of the issue surrounding foreign trained doctors. These statistics and trends are important for the issue of foreign-trained doctors because it suggests that there is a need to either have more doctors in an aging-population where there are already areas in the province that lack doctors, or that we need to consider revising the current rules applicable to relocate doctors to areas in need. In 2007, Ontario's population was 12.8 million. As shown in Table 1, at this time, Ontario's population is 38.8 percent of the total Canadian population with a growth rate of 0.8 percent. The age distribution of the 12.8 million people is as follows: 17.5 percent of the total population are in the 0-14 years-old category, 69.3 percent are in the 15-64 years-old age group and 13.2 percent are in the 65+ years-old category. The distribution of the population across the province according to the chart below from Statistics Canada notes that the Greater

Toronto Area (GTA) has 46.8 percent of the province's total population, Central Ontario has 21.6 percent of the total provincial population, Eastern Ontario has 13.0 percent of Ontario's population, South-Western Ontario has 12.4 percent of the total provincial population, North-Eastern Ontario has 4.4 percent of Ontario's population, and finally North-Western Ontario has 1.9 percent of the province's total population (Statistics Canada, 2006).

The *2006 Environmental Scan*, as shown in Chart 1, projected migration and immigration trends for Ontario, and indicated that from 2004 to 2013, net migration (for example, to Ontario from other countries, provinces and territories) will add more than 1.1 million to the province's population, accounting for 70 percent of the total population growth (Association of Colleges of Applied Arts & Technology of Ontario, (hereafter known as ACAATO) 2006, p.3). It is said that by 2031, net migration will add 2.9 million people to Ontario's population. Similarly, in the past immigration has been an important factor, contributing highly to population growth in the province. In 2004-05, the province received 130,000 new Canadians, which is equivalent to 53 percent of the total who immigrated to Canada (ACAATO, 2006, p.7). The study notes that there is uncertainty when it comes to projecting immigration levels, however taking into account the fluctuations that occurred in the previous decade and the targets set by the Canadian government, Ontario immigration projections by the Ministry of Finance range from 90,000 to 150,000 persons annually (ACAATO, 2006, p.7).

Figure 1 indicates that Ontario's population was 12.5 million in 2005 and is projected to reach a population of 16.4 million by 2031 (ACAATO, 2006, p.4). The same study indicates that in 2004-05, the province received 53 percent of all of Canada's immigrants, 130,000 in total. Although population growth will vary by region in Ontario, with the GTA being the fastest-growing, mostly due to immigration, the Northern regions are expecting a modest decline

throughout the next 25 years (ACAATO, 2006, p.4). As well, during this period of focus, the age distribution of the province's population will change to fewer youth and more seniors. It is projected that the proportion of children under the age of 15 years will fall from 18.5 percent to 15.4 percent, and the proportion of adults aged 65 and over will increase from 12.8 percent to 22.3 percent in 2031. Ontario's working-age population of ages 15 to 64 will rise from 68.8 percent in 2004 and peak at 69.6 percent in 2010. After that point, it will slowly fall to 62.3 percent by 2031 (ACAATO, 2006, p.4). With the projected population increase as well as the increase in the group of people over the age of 65, the issue of having more doctors in Ontario becomes more relevant.

As already mentioned, from 1996 to 2001, Ontario received almost 424,000 international immigrants over the age of 15 years. Another trend to examine within the immigration flow, and as shown in Table 2, is that the education levels of international immigrants coming to the province have increased and are now even higher than the non-immigrant Ontario population ages 25 to 44 (ACAATO, 2006, p.4). In 2001, only 59 percent of the province's population ages 25 to 44 possessed a postsecondary credential, compared with 72 percent of immigrants who came to the province from 1996 to 2001. There has also been a shift in the proportion of immigrants with university degrees and a decline in college credentials (ACAATO, 2006, p.8). Therefore over the past decade, immigrants moving to Ontario from foreign countries are more educated and more are from the economic class than the previously accepted family class that province has seen in the past. These figures are important to examine because within this group, there is a variation in the types of credentials received as it correlates to the number of foreign-trained doctors entering the province discussed later in the paper.

With the inflow of new immigrants to the province with higher levels of education received from their country of origin, it is also important to look at the current physician trends in Ontario. The *2005 Survey of Ontario's Physicians: Access Challenges Ahead*, which conducted an annual survey of the province's licensed doctors for the previous six years, indicated that the average age of practicing physicians is 51.7 years of age, an increase from 49.0 years of age in 2000 (College of Physicians and Surgeons Ontario, 2006, p.1). The steady increase in the average age of the physicians can be shown in Figure 2 and is a reflection of the fact that there are not enough physicians entering practice to offset these figures (College of Physicians and Surgeons Ontario, 2006, p.2).

The aging population of physicians in Ontario is tied in with the other problem of a decrease in the number of physicians accepting new patients. The decline can be seen in Figure 3 where in 2000, 38.4 percent of General Practitioners/ Family Practitioners (GPs/FPs) responding to the annual survey by the College of Physicians and Surgeons Ontario, indicated that they were able to accommodate new patients, and in 2002, that percentage dropped further to 31.7 percent (College of Physicians and Surgeons Ontario, 2006, p.7). Also indicated on the figure is the fact that the number of GPs/FPs accepting new patients has continued to drop where in 2005, only 11.4 percent were accepting new patients (College of Physicians and Surgeons Ontario, 2006, p.7). This is a real problem that many are struggling to deal with in their need to have a regular GP/FP who will keep track of their medical history.

The same survey indicates yet another problem added to the notion of a decline in GPs/FPs accepting new patients. Table 3 indicates the uneven distribution of GPs/FPs across the province accepting new patients. The areas below are separated by the first letter of the postal code of physicians' primary practice address. The highest percentage of GPs/FPs accepting new

patients is located in the metropolitan Toronto region, where 21.7 percent of GPs/FPs indicated in the survey that they are accepting new patients (College of Physicians and Surgeons Ontario, 2006, p.7). South central and Northern Ontario indicate 10.6 percent and 10.5 percent respectively, of GPs/FPs accepting new patients, which indicates the overall provincial percentages (College of Physicians and Surgeons Ontario, 2006, p.7). The results in Eastern and South-Western Ontario are of 4.7 percent and 4.5 percent of physicians accepting new patients respectively, substantially lower compared to the overall provincial percentage (College of Physicians and Surgeons Ontario, 2006, p.7). However, it is important to note that the survey points out that these values do not reflect the population need or density. Especially with the projected decline of the population in the northern parts of Ontario, it is difficult to assess the projected needs of certain areas in the province. The survey states that it is difficult to speculate about the impact of the low 4.5 percent in southwestern Ontario or the high percentage of 21.7 percent in Toronto, as neither informs us whether population needs are being met.

In relation to Ontario's Regional Population Distribution as indicated in the *2006 Environmental Scan*, between 1996 and 2004, population growth varied widely throughout the province. For example, regions that experienced increases include the GTA (an increase of 18.6 percent), Ontario's central region (an increase of 10.9 percent), Southwestern Ontario (an increase of 5.7 percent), and Eastern Ontario (an increase of 7.7 percent) (ACAATO, 2001, p.8). However there were also regions in the province that experienced decline: North-Eastern Ontario experienced a 5.9 percent population decline, while Northwestern Ontario experienced a population decline of 3.9 percent (ACAATO, 2001, p.8). As displayed in Table 4, these trends are projected to continue through to 2031. Most regions in the province will experience growth

with the exception of the North, with the GTA being the fastest growing region, mostly due to immigration (ACAATO, 2001, p.8).

By 2031, the GTA's population is projected to increase from 5.7 million in 2004 to 8.1 million, making the share of the total Ontario population to almost 50 percent in 2031 (whereas it was at 46 percent in 2004) (ACAATO, 2001, p.9). Similarly the population of Central Ontario will grow by about 858,700, with its share of Ontario's total population remaining unchanged at 22 percent at the end of the projection period. Eastern Ontario's population will increase by 429,000 and the population of Southwestern Ontario will grow by 335,600, however growth rates within the region will vary. Northern Ontario will continue the trend of decrease and is expected to experience an overall population decrease of 19,200 people between 2004 and 2031 at varying rates across the region (ACAATO, 2001, p.9). Table 4 gives the breakdown in percentages of the current and projected population share for the province by region,

This section has outlined the current and projected state of Ontario and given the relevant information pertaining to the current and projected doctor shortage in the province. The information presented in this section includes an increase in the number of immigrants moving to Ontario with higher levels of education, a general increase in the age of practicing physicians across the province, a low percentage of doctors accepting new patients in all parts across Ontario, and a projected increase in the population throughout the province. It is evident that something needs to be done in order to allow all residents, regardless of the region they are residing in, to be able to have a doctor they can regularly visit.

Part Two: Becoming a Doctor with a Foreign Degree in Ontario

Looking at the solution of having more doctors, whether they are foreign-trained or domestically educated is important, therefore this paper will now turn to addressing how a doctor

with foreign credentials becomes a qualified practicing doctor in Ontario. Table 5 is a list of the membership statistics of the Association of International Physicians and Surgeons of Ontario as of April 2002. It indicates that foreign-trained doctors from Iran, India and Pakistan make up 13.9 percent, 12.5 percent and 11.0 percent respectively of their members. It is interesting to note that nearly half of these foreign-trained doctors, 43.9 percent, are General Practitioners and that the gender divide in membership statistics is relatively equal, with 49.0 percent female and 51.0 percent male.

According to the McKendry Report (1999), in the late 1960s, one-fourth of Canada's new doctors each year were foreign-trained doctors recruited to come to the country. By the mid-1980s, predictions of a physician surplus and new policies regarding "physician self-sufficiency" started to change that trend and restrictions on foreign-trained doctors began to develop. The percentage of new practice licenses issued to foreign-trained doctors as a percentage of total new licenses in Ontario decreased from 21 percent in 1991 to only 14 percent in 1998 (Association of International Physicians and Surgeons of Ontario, 2002, p.8). Thus the chances that a foreign-trained doctor, who arrived before 1980, could practice medicine in Canada were actually similar to that of a Canadian-borne person who studied medicine in Canada, (95 percent and 92 percent respectively) (Boyd & Schellenber, 2008, p.4). However the chances of becoming a doctor for foreign-trained doctors arriving after the 1990s were dramatically reduced. Along with the changes in the number of foreign-trained doctors being issued licenses, there are also changes in the way this group of doctors are assessed and ultimately granted permits to practice in the province. Health consultant Robert Libbey says that currently there are approximately 250 training-position set aside every year under provincial International Medical Graduate programs outside of Quebec. The 250 positions includes six in BC, 20 (12 family medicine, eight

specialists) in Alberta, two in Saskatchewan, 12 in Manitoba, 200 (100 family and 100 specialists) in Ontario, and 14 in Newfoundland and Labrador (Canadian Medical Association, 2003, p.435). Similarly, according to the 2001 Census, there were about 5,400 individuals living in Canada who studied medicine in an institution outside of the country, who arrived at the age of 28 or older, and are between the ages or 32 and 54. This group accounts for 16 percent of the potential doctors available, who meet the minimal educational requirements to practice medicine in Canada (Boyd & Schellenberg, 2008, p.3).

The requirements for becoming a doctor with a foreign degree vary by province. At the moment, only Ontario, Quebec and British Columbia use specific assessment tools such as the Medical Council of Canada Qualifying Examination, language proficiency examinations and the Objective Structured Clinical Examination (all of which will be discussed further in this section of the paper) to evaluate candidates who will be admitted to residency programs (Nasmith, 2000, p.2).

In May 2000, the College of Physicians and Surgeons of Ontario commented:

> We have started with the premise that there are internationally trained physicians of the same clinical caliber as those who have achieved certification after residency and examination by the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada. There is no principled reason, from a standards viewpoint, why such physicians should be barred from practice in Ontario. Moreover, it is desirable that a certain number of foreign physicians relocate to Ontario to contribute diversity to the medical community in Ontario. Internationally trained physicians have made important contributions to medical practice in Ontario by the various and different perspectives that their backgrounds provide (Bennett, 2001, p.15).

Here, it is indicated that the College holds strong beliefs and commitments to inclusiveness of all doctors regardless of their country of origin or ethnicity, and shows great determination to achieve this goal. However, with the difficulty for a foreign trained doctor to achieve their goal, as will be shown next, there is an obvious discrepancy between what is presented in the College's commitment and the actual inclusion of a foreign trained doctor. This

statement could be seen to also be misleading as a foreign trained doctor looking to immigrate and practice in Ontario may be led to believe the province is welcoming in terms of foreign trained doctors or "immigrants of colour," however because institutional racism may be a factor in the decision making process, may have their future plans short-lived.

The Centre for the Evaluation of Health Professionals Educated Abroad (CEHPEA), a not-for-profit organization that is part of the Ministry of Health and Long Term Care of Ontario, is the organization that reviews foreign-trained doctors as candidates to become practicing doctors in Ontario. The organization provides evaluation and orientation programs to foreign-trained health professionals and states that it initially provides assessments for International Medical Graduates for direct entry training in Family Medicine and other direct entry specialties (CEHPEA, 2009). Furthermore CEHPEA's website indicates it offers written and clinical assessments for candidates applying for Postgraduate Year Two (PGY2) or Practice Ready Assessment (PRA) training and also offers the Pre-Residency Program for Family Medicine for candidates who have been matched to a Family Medicine residency training program in Ontario. Finally CEHPEA states it will administer the Orientation to training and Practice in Canada program (OTPC) for candidates who have received acceptance for a specialty residency training program or a PRA position in the province (CEHPEA, 2009).

A link in the CEHPEA website lists the mandatory assessment requirements for foreign-trained doctors, which are listed under eight categories: (1) Curriculum Vitae, (2) Canadian legal status, (3) language proficiency, (4) Medical Council of Canada Evaluating Examination (MCCEE), (5) Medical Council of Canada Qualifying Exam Part One (MCCQE1), (6) Medical Diploma, (7) Transcripts, and (8) Candidate Declaration. The candidate is asked to submit a Curriculum Vita which should include information on teaching and research, list of publications,

certificates, awards, scholarships, memberships, etc. This section also requires a photograph to protect the candidates' confidentiality and to ensure the integrity of their application. The photograph must be full face and be taken within 60 days of the date of application.

Secondly, the website states that "all applicants applying for assessment at the Postgraduate Year One (PGY1), Postgraduate Year Two (PGY2), or Practice Ready Assessment entry levels may apply to CEHPEA for assessment regardless of Ontario resident (or residency) status." (CEHPEA, 2009). To prove the application's legal status in Canada, s/he must provide a copy of one of the following: notarized/certified photocopy of Birth certificate with any photo ID; notarized/certified photocopy of Canadian passport, notarized/certified photocopy of Canadian citizenship certificate, Record of Landing; notarized/certified photocopy of Permanent Resident Card/Canadian Citizen Card; application to Citizenship and Immigration Canada for Permanent Resident status, or; a signed letter indicating intent to apply to immigrate to Canada.

Thirdly, according to the CEHPEA website for foreign-trained doctors, the candidate must demonstrate fluency in English or French through one of the following: (1) Test of Spoken English – Professional (TSE-P) Score Date, TOEFL Score Date, Essay Writing Score; (2) Test of English as a Foreign Language – Internet-based test (TOEFL-lbt) Score Date Writing Section Score; (3) Language Proficiency Form: Primary and Secondary School, which must be mailed directly from the Senior Academic Administrators of both schools confirming that all of the candidate's primary and secondary education was conducted completely in English or French; (4) Language Proficiency From: Medical School, which must be mailed directly from the Dean of the Medical School to the CEHPEA office confirming that the candidate's language of instruction and patient care was conducted completely in English or French; (5) WHO/FAIMER Language Option, which implies that if the language of instruction and the language of patient

care at the undergraduate medical school was conducted completely in English or French, then candidates can submit a copy or printout from the WHO website or book or the FAIMER listing the medical school which clearly states that the language of instruction is English or French; or (6) A pass result in the French proficiency test administered by the Office Québécois de la langue Française (OQLF) (CEHPEA, 2009).

The CEHPEA website also states that all applicants must achieve a passing result on the Medical Council of Canada Evaluating Examination (MCCEE) where a notarized/certified photocopy of the MCCEE Statement of Results must be submitted to CEHPEA. Similarly, all applicants must achieve a passing result of the Medical Council of Canada Qualifying Examination Part 1 (MCCQE1) where a notarized/certified copy of the MCCQE1 Statement of Results must be submitted to CEHPEA (CEHPEA, 2009). Finally, the website indicates that a notarized/certified copy of medical school transcripts is required. If the transcripts are not in English, they must be accompanied by a notarized translation (CEHPEA, 2009).

According to the information provided by CEHPEA online, all candidates must submit a non-refundable application fee of $150 with the application. PGY1 assessment candidates must pay a fee of $550 to participate in the General Comprehensive Clinical Examination (CE1), and advanced specialty candidates are required to take the Specialty Clinical Skills Examination (CE2) at a fee of $550. Finally, advanced specialty candidates also applying for PGY2/PRA assessment are required to pay a $275 fee to take the Specialty Written Examination (SWE) and the same candidates applying for PGY1 assessment are required to pay an additional $550 exam fee to participate in the CE1 (CEHPEA, 2009).

Another publication aimed towards giving greater information to foreign-trained doctors created by the Ontario Ministry of Health, indicates that each applicant must take many factors

into consideration when applying to practice as a doctor in Ontario. These factors include: the notion that there is no guarantee that the candidate will receive registration to practice in the province; the process for obtaining a training or assessment position and receiving registration to practice is complex; the candidate must be very committed, both personally and financially; and that the candidate must sign a Return-of-Service Agreement, which means that the individual will have to promise to practice in an under serviced community in the province where there is a shortage of doctors (Ministry of Health and Long Term Care, 2005, p.4).

In their *Submission to the Commission on the Future of Healthcare in* Canada, Association of International Physicians and Surgeons of Ontario (AIPSO) listed two examples of the barriers that affect foreign-trained doctors. The first example of a barrier is the evaluation of the candidate's knowledge of the principle fields of medicine. AIPSO says that while the evaluation of the medical knowledge of applicants for licensure is a legitimate purpose, the Medical Council of Canada Evaluating Examination (MCCEE) is redundant (Association of International Physicians and Surgeons of Ontario, 2002, p.10). The medical knowledge of all applicants for licensure is tested through the MCC Qualifying Exam (Parts 1 and 2), which all medical graduates must pass in order to become eligible for the Licentiate of the Medical Council of Canada. AIPSO says the content of the MCCEE and the Qualifying Exam Part 1 is similar, with material tested and knowledge evaluated in the former is fully covered in the content of the latter (Association of International Physicians and Surgeons of Ontario, 2002, p.10). The other example of a barrier affecting foreign-trained doctors is that the MCCEE is currently used as an eligibility requirement for foreign-trained doctors by the Canadian Residency Matching Service, the Ontario International Medical Graduate Program, and others. AIPSO believes this could be replaced by the Qualifying Exam (Association of International

Physicians and Surgeons of Ontario, 2002, p.10). Therefore AIPSO says the continued use of the MCCEE exam is a systemic barrier due to its redundancy. An increase in the time it takes to become a doctor in the province means that the candidate is also spending more time becoming a doctor that is really needed.

Part Three: The Long, Expensive and Disappointing Road for Foreign-Trained Doctors

In the past, the bulk of foreign-trained doctors immigrating to Canada were from Commonwealth countries and as a result of the professional and licensure connections, integrated into the Canadian physician workforce easily (Health Canada, 2004, p.3). However, in the 1980s to the mid-1990s, immigration and physician supply policies made it more difficult for potential immigrants declaring themselves as physicians to immigrate to the country. During this time some foreign-trained doctors from Commonwealth countries came to Canada on work permits with offers of employment. Thus there was a shift in ideology perhaps in terms of what was wanted in the county and subsequently requirements for licensure and change in immigration policy made it more difficult for foreign trained doctors to practice and obtain immigration status in Canada. Other immigrants, not from the Commonwealth countries, immigrated to Canada through family reunification programs or refugee programs, and although they had the intention to practice medicine in Canada, they were often unable to obtain licenses (Health Canada, 2004, p.3). Because a large number of these individuals did not declare their profession upon entering the country, the actual number of foreign-trained doctors living in Canada and working in other occupations in unknown.

There is also another group of foreign-trained doctors that arrived in the early to mid-1990s. These are Canadian students who enrolled in medical education programs outside the country as a result of the decrease in positions in Canadian medical schools, and who now

wished to return to the country to practice (Health Canada, 2004, p.4). In the mid-1990s, the shortage of physicians in rural communities resulted in communities putting pressure on governments and licensing bodies to create more flexible policies regarding timelines to meet all training and competency requirements for practice in order to facilitate the recruitment of doctors from outside of the country (Health Canada, 2004, p.4).

According to AIPSO, there are approximately 1,500 members in the association and another 700 members in other foreign trained doctor's organizations across Ontario. AIPSO's indicates that approximately 150 of its members were born and trained in Pakistan (Association of International Physicians and Surgeons Ontario, 2009).

In 2002, the Immigration Act of 1976 was replaced with the Immigration and Refugee Protection Act concentrating on skills, training and potential for successful integration into the Canadian workforce and society (Health Canada, 2004, p.4). The new Act was intended to be adaptable and responsive, and to choose workers with flexible, transferable skill sets rather than specific occupational backgrounds. It also provided for the creation of a new landing class for certain temporary workers, including international graduates of Canadian schools with Canadian work experience who meet the selection criteria as skilled workers (Health Canada, 2004, p.4). The Task Force on Licensure of International Medical Graduates believes that the newest legislation has the potential to ease the entry of foreign-trained doctors into Canada, which would lead to the increased numbers of foreign-trained doctors seeking to establish medical practice in the country (Health Canada, 2004, p.4). This legislation would give immigrants with higher educational achievements a better chance to immigrate to Canada as well as open the door to opportunity in the field they have chosen in their country of origin.

In October 1992, Morris L. Barer and Greg L. Stoddart published an article in the Canadian Medical Journal identifying five fundamental problems with health-workforce planning in Canada: (1) the number of postgraduate residency training positions exceeds the number needed to train current Canadian medical undergraduates, (2) the allocation of residency positions across specialties is not determined by or on par with the relative need for the various specialties, (3) the organization of the training programs is inefficient, (4) the funding of and the clinical service provision by residents are irrational and likely inefficient from an "opportunity-cost" view and (5) the training of some graduates does not encourage them to practice far from urban geographical areas (Barer & Stoddart, 1992, p.999). Their article also argues that given the desired ratio of general and family practitioners to specialists there is an excess of funded residency positions in the country (Barer & Stoddart, 1992, p.999). This article recommends that the overall number of funded residency positions for graduates of Canadian medical schools be brought into line with the number of positions required for the completion of their training (Barer & Stoddart, 1992, p.999).

In keeping with the above recommendations, in *The Appeal Process of Registration Decisions in Ontario's Regulated Professions*, it is noted that the licensure process for foreign-trained doctors to practice in Ontario has become a competition as opposed to being an assessment of safety and competency to practice (Association of International Physicians and Surgeons of Ontario, 2004, p.2). Similarly, while there are appeals mechanisms within the Regulated Health Professions, the nature of the appeals being appeals of licensure decision for foreign-trained doctors means that these appeals are not relevant to most foreign-trained doctors living in the province (Association of International Physicians and Surgeons of Ontario, 2004, p.2). The decisions regarding qualifications, experience, and competencies of foreign-trained

doctors which allow them to go towards the pre-requisites for licensure are made earlier in the process. Only those who have been selected for one of the 200 assessment/training positions available and then completed the required assessment/training and passed further licensure exams are only then able to apply for a license (Association of International Physicians and Surgeons of Ontario, 2004, p.2).

Another concern that arises with the issue of foreign-trained doctors is often a forgotten one concerning the country of origin of the doctor. Doctors are often classified as being highly-skilled, thus when entering Canada, the country of origin is actually losing a highly-skilled individual in their health community. Most often, the country of origin is a developing country. In their article *Brain Drain from Developing Countries: How can Brain Drain be converted into Wisdom Again?,* Sunita Dodani and Ronald E. LaPorte write about "the migration of health personnel in search of a better standard of living and quality of life, higher salaries, access to advanced technology and more stable political conditions in different places worldwide" (Dodani & LaPorte, 2005, p.487). In the 1970s, the World Health Organization published a 40-country study on the flow of health professionals which indicated that close to 90 percent of all migrating physicians were moving to just five countries: Australia, Canada, Germany, UK and USA (Dodani & LaPorte, 2005, p.487).

In 1972, approximately six percent of the world's physicians (140,000 physicians) were located outside their countries of origin where over three-quarters were found in only three countries (the USA, UK and Canada) (Dodani & LaPorte, 2005, p.487). The main countries of origin at this time were India, Pakistan and Sri Lanka, as also indicated in the AIPSO membership statistics. In many cases, because of this outsourcing of foreign-trained doctors, the country of origin is not only losing its investment in the education of health professionals, but

also the contribution of these professionals to health care (Dodani & LaPorte, 2005, p.488). The issue was also raised by Dr. William McArthur in the Fraser Forum, when he said that foreign-trained doctors coming from developing countries where their skills are urgently needed is "seen by some as a form of reverse foreign aid where those of us who are prosperous promote the migration of skilled and scarce workers from countries where they are desperately needed" (McArthur, 1999). Harald Bauder has gone even further by referring to his problem as "brain abuse" where the country from where the foreign-trained doctors has immigrated loses that brain, while the country who receives the doctor should have benefited from that skill does not accept that brain. Ultimately, the result is that neither country utilizes the quality and skill of that individual (Bauder, 2003, 715). This aspect of the brain-drain from developing countries is an area to consider when dealing with foreign-trained doctors practicing in Canada.

Some scholars site the difficult assessment process as being part of a much bigger problem. Institutional racism practiced by members in the medical community and federal and provincial government that are in a position to grant or ban access to licensure in the province, may be a factor in the difficult process and low numbers of foreign-trained doctors actually receiving their license in Ontario. Laws and policies set out for foreign-trained doctors may be questionable as research in Quebec, the United Kingdom, and New Zealand have pointed out (CMAJ, 2009, p.158).

In March 2009, the Montreal Gazette published an article concerning alleged discrimination of foreign-trained doctors seeking to work in Quebec. The article noted that the Coalition of Associations of Foreign Trained Doctors called on the province to hold a parliamentary inquiry to examine the alleged discrimination. Dr. Comlan Amouzou, spokesperson for the group, accused Quebec's four medical schools of refusing to hire foreign-

trained doctors to fill residency positions in hospitals. He noted that more than 200 international medical graduates have passed equivalency exams by the Quebec College of Physicians, but the hiring committees at Quebec's medical schools have systematically refused to fill residency positions even though 94 positions are vacant across the province (Bédard, Montreal Gazette, 2009).

In an article published in the *Canadian Medical Association Journal* called "Doctors crossing borders: Europe's new reality," systemic racism is noted as a reason for 2,205 Polish general practitioners not having their licenses recognized in the United Kingdom since 2002, while the number of German physicians practicing in the United Kingdom rose from 383 to 8,000 in 2003 (CMAJ, 2009, p.158). The General Medical Council registered 11,630 new doctors in 2007, meaning that approximately 15 percent of all new registrants in the UK since 2003 came from Germany. In turn, this means that Germany has had to recruit more doctors from other countries, such as Greece, Austria, Poland and other European nations, to fill the vacancies. The institutional racism that affects Polish doctors in the UK points to the general attitude expressed by the UK public. In 2007, Polish people reported 42 racially motivated attacks again them, compared with 28 in 2004 (BBC News, 2008). The BBC also reports that there have been a number of reported incidents of attacks on Eastern Europeans in recent years around the UK. Interestingly, Dr. Jean Turner, chief executive officer of the Scottish Patients' Association, says "the feedback from patients in Scotland is that they do no want doctors from another country... Importing doctors who do not know how our system works, and who, with the best will in the world, may have language difficulties, is fraught with danger." (CMAJ, 2009, p.161). This concern was compounded by a report from the UK General Medical Council stating that 35 foreign-born doctors had lost their licenses to practice in 2006. However in response to

this report, the British Medical Association suggested the higher incidence of foreign-born physicians who lost their practicing license might be the product of a culture of institutional racism within the National Health System. This argument was supported by a July 2008 report by the Department of Health's Chief Medical Officer, which concluded that racism was a "cause for concern" (CMAJ, 2009, p.162).

In New Zealand, with more than 40 percent of doctors on the medical register being foreign-trained, had an investigation into the safety of foreign-trained doctors, which found language difficulties to be one of the main complaints from "frightened, frustrated and sometimes 'racists' patients" (Sunday Star Times, 2008). The research into six years of complaints to Health commissioner Ron Paterson's office, found Indian-trained doctors receiving more complaints per head than any other nationality. Paterson says patients are more likely to complain about doctors with brown skin who have English as a second language. He said,

> putting aside any question of racism, one can understand that when people are frightened and have been waiting a long time and then get to see usually a junior doctor and they have some difficulty understanding what they are saying, that might be the tipping point. We are increasingly going to strike doctors with foreign accents who aren't quite as easy to understand and that's a fact of life and we'd find the same thing if we landed up in hospital in Australia, Canada or the UK. We're going to have to get used to it. (Paterson, 2008)

However, Paterson believes there was no serious cause for concern about foreign-trained doctors in terms of their standards of care. He said that most of the complaints were resolved without findings that doctors had breached patient rights or caused serious harm (Paterson, 2008). The report analyzed complaints in seven specialties in which more than 100 complaints had been received. Although Indian-trained doctors were over-represented in complaints against General

Practitioners, obstetricians and gynecologists, Paterson said the sample sizes were small and several complaints against one or two people could skew the numbers (Paterson, 2008).

The issue of racism when it comes to foreign-trained doctors appears to be present not only institutionally, but also as a broader view expressed by the public when selecting their general practitioners. This is suggested by studies in the United Kingdom as well as in Australia and also suggested by a call for review of accepting foreign-trained doctors in Quebec (Bédard, 2009).

Part Four: A look at Other Provinces in Canada

This paper will now turn to addressing what other provinces have done in moving forward with the issue of foreign-trained doctors in Newfoundland and Labrador, British Columbia, and Quebec.

Newfoundland & Labrador – The Clinical Skills Assessment Training program (CSAT) was established in 1997 in response to difficulties in recruiting physicians to rural Newfoundland. Its mandate is to provide individualized assessments of physicians referred to the program by the licensing authority and provide training to physicians who have been determined to need less than six months of additional training (Bennett, 2001, p.12). The aims of the program are to carry out a fair, reliable and valid assessment of the knowledge, skills and competencies of physicians; to provide effective individualized enhancement; and to evaluate the effectiveness of the enhancement through in-training evaluation and re-assessment (Bennett, 2001, p.12). The administration of the program is run by the division of Professional Development, Faculty of Medicine at Memorial University, and is limited to Family Medicine, and also requires partnerships with the Newfoundland Medical Board, regional health boards, Department of Health and Community Services, and the Newfoundland and Labrador Health and

Community Services Association (Bennett, 2001, p.13). The assessment model focuses only on the educational needs of the foreign-trained candidate using four different assessment tools, (1) Multiple Choice Questions, (2) Therapeutic, (3) Formal Oral, and (4) Standardized Patient Encounters (Bennett, 2001, p.13). It measures varying competencies including core knowledge, data gathering, clinical judgment, decision-making, communication skills, and documentation (Bennett, 2001, p.13).

The first assessment of the program was completed in February 1999, and up to 2001, a total of 56 assessments have been done (Bennett, 2001, p.13). Of the assessments done in this two-year period, 39 physicians (70 percent) have proceeded with the training program, while the other 17 (30 percent) required a minimum of one year of training. In this two-year period, 27 physicians have completed the training and have been working, six went on to training, three have withdrawn from the program, one went to Dalhousie University, and one is pending results. (Bennett, 2001, p.13). The candidates for the program have been largely foreign-trained medical graduates (51, or 91 percent), while the remaining five (9 percent) have been referred for other reasons not specified (Bennett, 2001, p.13). A later study by Marie Mathews, Alison C Edwards and James T.B. Rourke, used administrative data from the Newfoundland and Labrador College of Physicians and Surgeons, the 2004 Scott's Medical Database, and the Memorial University postgraduate database, and identified family physicians/general practitioners who began their practice in NL in the period 1997-2000 and determined where they were in 2004 (Matthews, Edwards & Rourke, 2008, p.3). They concluded that provisional licensing accounted for the largest proportion of new primary care physicians in NL but does not lead to long-term retention of foreign-trained doctors. However they also suggested that foreign-trained doctor retention is

no worse than the retention of graduates from Canadian medical schools (Matthews, Edwards & Rourke, 2008, p.2).

The study indicated that nearly half of the physicians in focus were provisionally licensed foreign-trained doctors, making up approximately 30 percent of the physician workforce in NL, whereas in Canada it is only approximately 5 percent (Matthews, Edwards & Rourke, 2008, p.8). Although foreign-trained doctors make up a large proportion of newly licensed physicians in NL, only a few remain in the province one year after earning full licensure (Matthews, Edwards & Rourke, 2008, p.8). The study also indicates that in 2004, 70.1 percent of foreign-trained doctors remained in Canada (25.6 percent were working in Western Canada, 62.7 percent in Ontario, and 11.6 percent in the Maritimes) (Matthews, Edwards & Rourke, 2008, p.3). As well, the majority of these foreign-trained doctors were working in urban communities. The study concluded that NL provides an entry point to practice elsewhere in the country and that most foreign-trained doctor's move to urban centers where there is a bigger diversity of cultures and these foreign-trained doctors are able to find a larger number of people who share their ethnic background (Matthews, Edwards & Rourke, 2008, p.9).

British Columbia – In British Columbia, NDP leader Carole James has proposed to increase the number of foreign-trained doctors practicing in BC as a way to alleviate the shortage of doctors in the province. She stated that the province would benefit by increasing the number of general and specialized residencies for foreign-trained doctors as

> foreign-trained doctors are an untapped resource for BC's ailing health care system... Over the last four years, the Gordon Campbell government has done nothing to make it easier for foreign-trained doctors to get the credentials they need to practice in BC. My plan would change that. (James, 2005).

James has proposed to increase the number of residencies in the province from six to twenty for general practitioners and create five new residencies for specialists. James says this would give

more foreign-trained doctors the opportunity to use their skills helping communities throughout the province. She notes that the additional residencies require an additional $5 million annually from the province, however the additional funding is valuable given the fact that the majority of the expense of educating these doctors was actually already done outside the province (James, 2005).

James' plan also included working with the federal government to ensure new money allocated in the 2005 Federal Budget for foreign-trained doctors is used to create national assessment standards to ensure foreign-trained doctors meet Canadian standards for treatment. She states: "Providing for the health care needs of British Columbians requires a comprehensive approach to doctor training and recruitment... My plan to put foreign-trained doctors in practice is an important and cost-effective part of the solution." (James, 2005). James bases her plan on the notion that BC requires more than 400 new physicians each year to replace those retiring, moving to other jurisdictions, or reducing the time spent practicing (James, 2005).

Quebec – In October 2007 Quebec announced that it will grant permanent permits to foreign doctors after five years in Quebec rather than continue the current practice of renewing temporary permits annually. The announcement comes after a denial from the College des Medecins Du Quebec in May of 2007 that it was blocking foreign doctors from practicing in the province (Fieldman, 2007). This will ease restrictions on foreign-trained doctors where the aim is to improve the lot of thousands of Quebecers who are without a family doctor (Fieldman, 2007). Research indicates that the province is short 800 family physicians, and an estimated 800,000 people do not have a general practitioner (Fieldman, 2007, p.A1). As well, according to Statistics Canada, 24.8 percent of Quebecers age 12 or older do not have a GP, compared with 8.8 percent in Ontario and 14 percent across the country (Fieldman, 2007, p.A1). Unlike

immigrants looking for recognition for their medical studies, these foreign-trained doctors were actively selected and recruited by the province to fill gaps in hospitals, universities, clinics and faraway regions lacking in human resources (Fieldman, Charlie, 2007, p.A1). A restricted permit allows a doctor to work temporarily, but only in a specific geographical area, and after completing a three-month supervised period in a hospital. Approximately 350 physicians from outside the country and the United States now work in Quebec on such permits (Fieldman, Charlie, 2007, p.A1).

It is recognized that the issue of foreign-trained doctors is one that is highly debated across the country. It is evident from the examples listed above that it is not only an issue in Ontario, but also one in Newfoundland and Labrador and Quebec, and most likely in other provinces as well.

In April 2002, the University of Calgary hosted a forum to discuss strategies for the successful integration of foreign-trained doctors, which included 84 participants, who were associated with the government, faculties of medicine and medical licensing and credentialing bodies (Health Canada, 2004, p.4). During this discussion, all attendees acknowledged that the entry process for foreign-trained doctors is different in each jurisdiction, the processes are not coordinated across jurisdictions, and entry differences have led to several human rights challenges. A key issue that was brought to attention from the symposium was the need to have a more flexible approach to assessment that would reliably test the competence of the physician to achieve the standard set for Canadian medical graduates.

The forum participants also noted that better information about medical licensure and medical practice in the country should be made available to foreign-trained doctors prior to entry into Canada (Health Canada, 2004, p.5). They proposed the development of a guide that would

provide the most recent information and identify the steps toward Canadian licensure and would include: criteria for access to residency training through the Canadian Resident Matching Service (CaRMS); information concerning the availability of provincial assessment and training programs and eligibility criteria; and the certification process of the College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada (RCPSC) (Health Canada, 2004, p.5).

When examining each of the provinces discussed above, it is evident that there are still problems with the proposals and actions they have undertaken to address the issue of foreign-trained doctors. The major issue that none of the provinces have proposed a solution to is that all three provinces still have the issue of relocation once foreign-trained doctors are granted their licenses to practice. Due to Charter rights, there is nothing to stop these doctors from relocating to urban areas (where the bulk are most likely and proven to go), and this causes problems with under-serviced communities.

Part Five: Recommendations

This paper will now turn to addressing the different principles and recommendations put forth by the Association of International Physicians and Surgeons of Ontario, College of Physicians and Surgeons Ontario, Task Force of Licensure of International Medical Graduates, and the Medical Council of Canada Project Management, as they pertain to foreign-trained doctors in Ontario. The issue of re-location will be addressed here with hopes to solve the problem concerning a lack of doctors in rural and under-serviced communities.

The Association of International Physicians and Surgeons of Ontario (AIPSO), which represents nearly 1,100 physicians in the province who are licensed to practice in other jurisdictions, has called for the stakeholders across the country to re-examine the existing

provincial eligibility requirements. AIPSO is a non-profit independent professional association, formed in 1998 by a coalition of groups of foreign-trained doctors settled in communities across Ontario. Their goal is to ensure that foreign-trained doctors are integrated effectively and equitably into the Canadian health care system. As stated on their webpage, AIPSO's objectives include: to facilitate access to the licensing process for internationally trained physicians; to work collaboratively with other stakeholders to identify and develop appropriate assessment, orientation, upgrading and integration programs for internationally trained physicians; and to provide information to members on licensing and meaningful employment in the healthcare field (AIPSO, 2009). As shown in Table 5, the statistics of AIPSO members as of 2002 is listed, however does not indicate the complete numbers as non-membership statistics of foreign-trained doctors are not included.

AIPSO believes that a national system should be developed based on four principles. The first principle is **coherence and coordination across jurisdictions**. This means that the licensing policies, programs and program eligibility criteria should be made as consistent as possible across Canada (Association of International Physicians and Surgeons of Ontario, 2002, p.14).

The second principle stated by AIPSO is one of **efficiency and effectiveness in moving qualified international physicians who meet Canadian standards into practice**. Efficiency and effectiveness should be measured in terms of the number of physicians licensed, the time it takes from their arrival in Canada, and the cost both to the individual and to the system (Association of International Physicians and Surgeons of Ontario, 2002, p.14).

The third principle consists of **equity, constitutionality and respect for the rights of Canadian residents and citizens who were trained in other countries.** This means that

Canadian citizens, internationally-trained physicians are protected under the Charter of Rights and Freedoms, and that the policies and programs related to assessment and licensing of internationally-trained physicians must meet the requirements of the Charter (Association of International Physicians and Surgeons of Ontario, 2002, p.17).

The last principle stated by AIPSO is one of **transparency and accountability in regulatory practices**. This means that occupational regulatory bodies are accountable to the public. This accountability includes the equitable and transparent exercise of their self-regulatory powers (Association of International Physicians and Surgeons of Ontario, 2002, p.17).

In June 2002, the Task Force of Licensure of International Medical Graduates was created to help the integration of qualified foreign-trained doctors into Canada's medical workforce (Health Canada, 2004, p.7). In September 2003, the Task Force proposed six recommendations to achieve their aims in its report. The recommendations were made to the Advisory Committee on Health Delivery and Human Resource and included. (In parentheses are suggestions made by Dr. Rodney Crutcher, co-chair of the Taskforce as well as Director of the Alberta International Medical Graduate Program, as to how each of the recommendations could be developed): (1) Increasing the capacity to assess and prepare IMGs for licensure. (Developing a national assessment consortium). (2) Work toward standardization of licensure requirements. (Although it would not be possible to achieve exact coherence of language, it is possible to work toward standardized licensure requirements). (3) Expand or develop supports/programs to assist IMGs with the licensure process and requirements in Canada. (Depends upon developing a clear roadmap so everyone involved can understand the complex system, and at the moment, success is due to the sheer persistence on the part of the foreign-trained doctor). (4) Develop orientation programs to support faculty and physicians working

with IMGs. (Doctors are working at their capacity right now and will need support so that they can gain the skills and knowledge needed to do assessments in a cross-cultural context. At the moment, most people who work with foreign-trained doctors have no training in it). (5) Develop capacity to track and recruit IMGs. (This needs to happen earlier on and with greater accuracy so that the skills of foreign-trained doctors can be incorporated into the health care system). (6) Develop a national research agenda, including evaluation of the IMG strategy. (Outcomes must be defined and data tracked) (Health Canada, 2004, p.9).

The above recommendations offer solutions of support and standardization of the current mandatory assessment process as presented on the CEHPEA website. They offer a better explanation of what is expected and required from candidates, and appear to make the process standardized across the country. This would bring greater clarity to potential foreign-trained doctors wishing to apply to practice in Ontario. These recommendations would tie together with the recommended principles set out by AIPSO if implemented.

Similarly the Task Force of Licensure of International Medical Graduates also introduced a framework for foreign-trained doctors, as shown in Figure 4. The framework reflects the challenges that candidates face, and guide the development of "a fair, unbiased and efficient approach to the competency assessments" of each foreign-trained doctor (Health Canada, 2004, p.8). The plan would allow access to the process through a common information site which would include not only instructions on how to apply for licensure, but also information regarding the health system in Canada, details on how to apply for immigration, and an orientation to the country and locations where one may find employment (Health Canada, 2004, p.8). The framework also calls for a self-assessment that would permit foreign-trained doctors to determine

their ability to pass the required licensure examinations, following which the candidate would apply to the appropriate licensure authority (Health Canada, 2004, p.8).

The framework calls for the creation of a credential verification service that would centralize the task of verifying the candidate's credentials as well as require the adoption of common processes by all medical licensing authorities to screen the foreign-trained doctor's application. At this point, depending on the assessment of medical education, the medical licensing authority may require the candidate to undertake additional post-graduate training if the board feels the skills of the foreign-trained doctor do not meet the mandatory requirements. The framework also reflects the physician resource requirements of the provinces and territories. Therefore the selection of a foreign-trained doctor for assessment or training will be determined mostly by the employer who is prepared to offer a position to the physician (Health Canada, 2004, p.9). Finally, the framework indicates that certification (from either the CFPC or the RCPSC) is important as it represents the achievement of "discipline-specific competency" in the country (Health Canada, 2004, p.9).

The framework has many benefits. It provides a common point of access for information about the healthcare system and licensure in Canada; it builds on the licensure process already in place; it builds on the learning and experience that foreign-trained doctors received from their country of origin; it provides these doctors with the opportunity for additional post-graduate training to meet the standards of their Canadian counterparts; and it gives governments the flexibility to address their medical resource requirements by supporting candidates with the skills and training required to meet the needs in their communities of practice (Health Canada, 2004, p.9).

Similar to the above recommendations and the framework by the Task Force of Licensure of International Medical Graduates, the Medical Council of Canada Project Management team has made a list of five recommendations dealing with the establishment of a National Assessment Collaboration (NAC). First, the plan calls for the creation of a program to implement the NAC's recommendations for national processes and standards for assessing IMGs for licensure as outlined in the Maguire Report and supported by the Expert Panel. Second, the plan indicates that concurrently, with support from Health Canada, the establishment of a permanent group to oversee implementation of the NAC's recommendations for national processes and standards for assessing IMGs for licensure is necessary. Third, as soon as possible, the plan calls for bringing IMG program leaders from across the country together with the national assessment bodies to establish the common standards as per the first recommendation. Fourth, although regional assessment programs are to be encouraged, the plan calls for better coordination and assigned development plans. Finally, the Conference of Federal, Provincial and Territorial Deputy Ministers of Health should ask the national assessment bodies to begin a process to establish a national assessment consortium or equivalent structure (Medical Council of Canada, 2005, p.5).

Recommendations sought out by the Medical Council of Canada Project Management Team reflect one that there needs to be more transparency in the decision-making process. With the creation of a permanent group to oversee the implementation of the recommendations, as well as creating common standards, as already put forth in the *Report of the Canadian Taskforce on Licensure of International Medical Graduates*, it is evident that health professionals and experts in the area of foreign-trained doctors are on a similar path to reaching solutions to the assessment process.

In a 2001 forum regarding *Doctor Shortages and the Integration of International Physicians* discussions were held in an effort to address solutions to physician resource concerns; in particular, ways in which Canada can more effectively utilize the skills, knowledge and experience of foreign-trained doctors living in the country (Bennett, 2001, p.2).

There is another argument that looks at whether the province currently has enough domestic resources and if it is in fact necessary to seek the aid and acceptance of foreign-trained doctors in the province. Robert G. Evans notes that there seems to be an agreement among students in the health care field that there needs to be more services provided in some areas or by some persons being matched by an oversupply in others (Evans, 1976, p.151). He further goes on the say that the existing level of medical service utilization overuses physicians relative to other less highly trained personnel, therefore it is possible to have a physician surplus in a technical sense even in the presence of a shortage in the medical field (Evans, 1976, p.151). In terms of having immigrant physicians, Evans says that either foreign-trained doctors are perfect substitutes for the domestic variety, or they are not. He says, domestic trainees are very expensive and they tie up educational resources, while foreign-trained doctors are "free" because they have already acquired their education and medical training from institutions in their home countries (Evans, 1976, p.154). He adds that the restriction of immigrants is identical to a tariff in that it restricts access to a low-cost source and lowers the real income of all Canadians, but just like a tariff it raises the incomes of domestic producers of physicians (Canadian medical schools and their faculties, and Canadian medical students) (Evans, 1976, p.154).

However, Evans also indicates that there are socializing issues concerning foreign-trained doctors. Evans notes that the maintenance of internal cohesion in the Canadian medical field is an important problem and such cohesion is likely to be threatened by recruiting foreign-trained

doctors from a diversity of cultural and educational backgrounds (Evans, 1976, p.155). Along with this negative aspect of recruiting a foreign-trained doctor, Evans also mentions the notion that there is an argument stating that domestic-trained physicians are in some sense 'preferred' by patients and that foreign-trained doctors provide a 'lower quality' of care (Evans, 1976, p.156). He goes on to say that no quality monitoring of physician performance takes place after medical school (Evans, Robert G., 1976, p.157). A similar question was posed by Dr. William McArthur in the Fraser Forum, who asked the question: "Is it fair to deny young Canadians the opportunity to pursue careers in medicine, or other areas of scholastic endeavor, because of our historic commitment to immigration?" (McArthur, William, 1999). It is suggested, and discussed above, that this form of racism is present in the institutional selection of doctors, but also in the general public's perception of their ideal doctor. It therefore may be necessary to look into ways to educate the general public that these ideals are racist and not only affect the opportunity for a foreign-trained doctor to practice in Canada, but also may affect the general health of the population since there is a real doctor shortage, as previously mentioned in this paper.

The conclusion of the *2005 Survey of Ontario's Physicians* indicates that it is more plausible approach to take from the current resources from the province and guide the individuals to go into medical practices that are currently low in numbers or have low projected numbers. This is shown in the recommendations made by the College of Physicians and Surgeons Ontario, which include: significantly increase domestic capacity by increasing enrollment in Ontario medical schools; encourage medical students to train in family medicine by increasing the attractiveness of practicing primary care medicine; significantly increase the postgraduate training capacity; market Ontario as a great place to work for health professionals and encourage

Ontario physicians practicing in other jurisdictions to return; create a health human resources planning body; and promote and implement collaborative care models (College of Physicians and Surgeons of Ontario, 2006, p.10). Although there is one recommendation that pertains to assisting foreign-trained doctors in the accreditation and assessment process, the recommendations more generally point to aiding the already established institutions and domestic students. This can be interpreted as a form of institutional racism as the established medical communities shows favouritism toward Canadian-born medical graduates. This racism in turn could significantly affect the chances for foreign-trained doctors to become doctors in Ontario.

The above recommendations look at ways to solve the issue of doctor shortages and are important because they do not pertain specifically to foreign-trained doctors, but to the general issue of medical-resource planning in the province. An important element to remember is that allowing more foreign-trained doctors to practice in the province does not remedy the issue of a lack of physicians in certain areas of the province. Thus it is important to look at ways to encourage all doctors to practice in areas that are or are projected to be short on medical resources. The above recommendations offer viable suggestions but need clearer plans for implementation, such as the ways to increase the attractiveness of practicing primary care medicine, or how to market Ontario as a place to work for doctors. Although there are suggestions made in this area, this does not take away from the notion that they may not be viable solutions if institutional racism does exist in the Canadian medical arena.

Conclusion

The issue of foreign trained doctors in Ontario is one that is not about simply examining the methods of how they are assessed. There are more complex issues involved, as this paper has briefly demonstrated, such as the issue of 'brain-drain' from developing countries and the

issue of needing to have better doctor resource planning across the province. In addition, many authors have suggested that institutional racism may exist in the medical arena. There is no doubt that there are concerns with the assessment, credentialing and residency system that is currently in place for foreign-trained doctors, and it is evident that the current process has flaws in all these areas and recommendations brought to light by the experts in this area must be carefully examined so that the ones deemed fitting may be implemented.

It must be identified whether or not the problem lies with a shortage of doctors in Ontario, or if the problem is one of mal-distribution of current resources in the province. If the problem is of shortage, there are a number of recommendations to look at as offered in the *International Review of Health Workforce Planning.* These recommendations include: introducing retraining incentives to re-skill professionals to skill areas of short supply; introducing mobility incentives to encourage relocation to areas of short supply; increasing education intakes; increasing the flow of foreign providers into the workforce, and increasing the use of technology to expand available provision (Health Canada, 2002, p.25). They are all plausible solutions worth testing to examine whether they work to solve the issues at hand. However, if the problem lies with a mal-distribution of the current resources that are already in the province, then alternative remedies must be examined. These solutions may include, but are not limited to: expanding opportunities for education in under-serviced areas, and increasing the enrollment of under-represented minorities in school and residency programs (Health Canada, 2002, p.26).

On the one hand, Dr. Wootton has suggested that there is a problem in using foreign-trained doctors as a solution to physician shortages, more evident in rural areas, and that the issue is more of a problem with distribution of medical resources (Bennett, 2001, p.4). He also argues

that the issue that physician shortages are a "made in Canada problem" and that the solution should also be made in Canada. He said that statistics have shown that the selection of foreign-trained doctors for rural practice does not differ from the prevailing practice among Canadian graduates and the problem remains one of distribution and needs to be addressed structurally by looking at the root issues of rural recruitment (Bennett, 2001, p.2). On the other hand, and as the balance of this paper has discussed, there is a serious flaw in terms of redundancy, the difficult access to appeals, the long and expensive process, and the seriousness of the competition that each foreign-trained doctor must undergo to have a glimpse of hope to becoming a qualified doctor in Ontario. This is the reality of the situation and it is for that reason that regulatory bodies, universities and training institutions, related provincial and federal ministries, community district health councils, community health centers, hospitals, and international physicians have had so many recommendations put forth that call for change to the matter. It is important to remember, as presented in the demographics section of this paper that with the current projection of 16.4 million people in Ontario by the year 2031, the general issue of doctors in the province is one that needs to be addressed seriously.

However, there are some promising developments in this area. In 1999, the McKendry Report was released with recommendations, including the expansion of the Ontario International Medical Graduate Program from 24 to 36 residency positions. In addition, the report of the Expert Panel on Health Human Resources was released in May 2001 with some recommendations implemented almost with immediate effect. Three clinical education campuses have been agreed for establishment of rural training in Thunder Bay, Sudbury, and Windsor (Bennett, 2001, p.2). Although these campuses are not targeted for foreign-trained

doctors, it increases the number of spots available to all training doctors looking for residency positions.

As well, in 2006, Ontario introduced the Fair Access To Regulated Professions Act, which aims at "breaking down barriers, and helping internationally trained professionals put their global experience to work in their field of expertise" (Ministry of Citizenship and Immigration, 2006). According to the Ontario Ministry of Citizenship and Immigration website, the Act would require regulatory bodies to adopt fair and transparent registration processes by: (1) reviewing their requirements for registration; providing complete information about how the registration process works, the approximate amount of time it would take to get a decision, fees required, and the criteria for acceptance into the profession; (2) deciding whether an individual is successful or not in obtaining a license within a reasonable time frame; (3) providing candidates with written reasons for the decision; (4) ensuring applicants have the right to an internal review or appeal if they do not agree with the decision; and ensuring officials making decision on registration, internal reviews or appeals are trained so that they have knowledge of the processes (Ministry of Citizenship and Immigration, 2006). To ensure these requirements are met, a Fairness Commissioner has been appointed to assess and oversee auditing and compliance with the legislation. The Fairness Commissioner's role helps ensure that regulatory bodies treat all applicants fairly by: (1) requiring bodies to submit annual reports to ensure their admission practices are fair; (2) conducting an audit of the registration practices and procedures of regulatory bodies every three years; (3) may issue a compliance order to regulatory bodies that do not meet with the requirements; Provides advice to the Minister and government on the fairness and the transparency of registration processes (Ministry of Citizenship and Immigration, 2006). Finally, under the legislation, the courts could levy fines of up to $50,000 for an

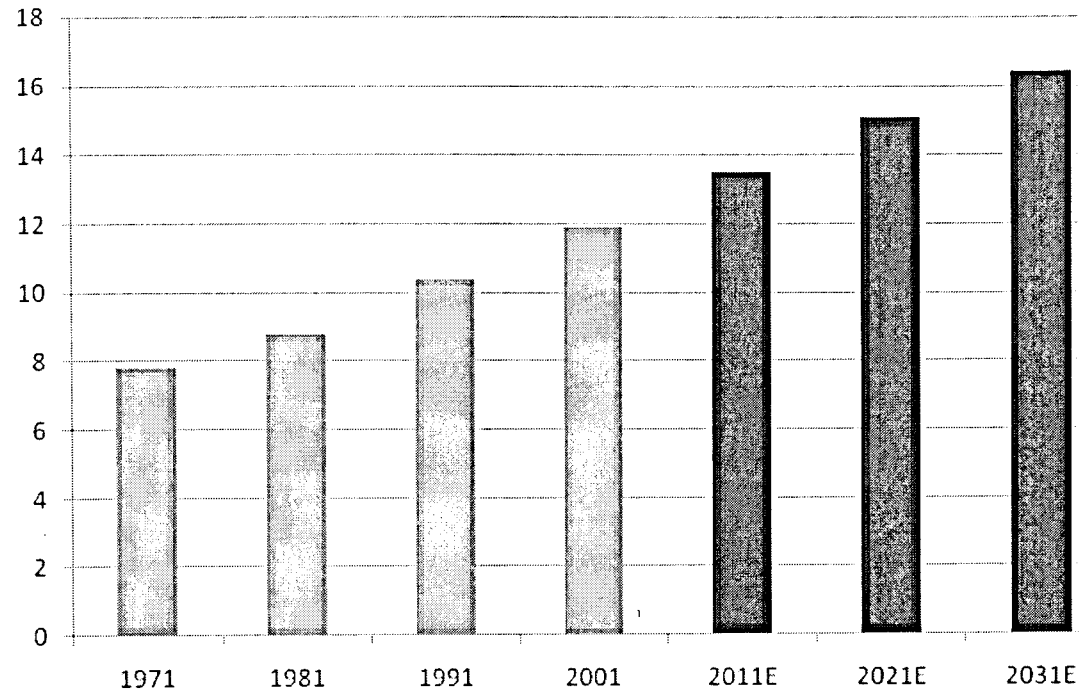
individual and up to $100,000 against a corporation for certain offences, including failure to comply with an order (Ministry of Citizenship and Immigration, 2006). These examples are just some of the steps taken over the past few years. Change however will be an ongoing process and requires greater action in order to facilitate the appropriate methods to make the playing-field equal for foreign-trained doctors amongst all other domestically-trained doctors in Ontario.

This paper has argued that foreign-trained doctors are important to physician resource planning in Ontario and there needs to be reform to the current licensing requirements to recognize their credentials in the province. This paper has looked at the demographic overview of Ontario and examined the differing trends across the province from the rural communities to the larger cities. It has then shown the doctor-to-patient ratio to discuss the general shortage of doctors in certain areas. The paper then addressed the current rules and regulations that foreign-trained doctors need to fulfill in the accreditation process in order to become licensed practicing doctors in Ontario, and has discussed the application process as well as a general time-line of how long the average foreign-trained doctor will have to endure the accreditation process before being able to practice in the province. The paper then went on to discuss how these restrictions ultimately affect many of the communities in their need of physicians and has also looked at how the accreditation process affects other foreign-trained professionals wishing to practice in the Ontario. The paper further examined Newfoundland and Labrador, British Columbia, and Quebec and looked at how they have each dealt with foreign-trained doctors as well as discussed how work still needs to be done even in these provinces. The paper then turned to look at the varying recommendations for changes as put forth by members of the medical community and public officials and examined each of these recommendations and assessed whether they would be feasible or if issues were over-looked.

The issue of institutional racism is both difficult to address and to prove. However, with the level of difficulty a foreign trained doctor must endure to achieve doctor status in Canada, there is an apparent flaw in the system that this paper has suggested and many scholars have argued, may be a result of institutional racism. It is important to remember that foreign-trained doctors in Ontario are not looking for exemptions from standards or shortcuts into the system, rather they want the opportunity to be assessed, oriented, provided with additional training if necessary to fill specific gaps, and move into practice, through a system that meets a set of fair criteria (Association of International Physicians and Surgeons of Ontario, 2002, p.3). The criteria and principles as outlined by the Association of International Physicians and Surgeons of Ontario (AIPSO) include coherence, effectiveness, equity and accountability (Association of International Physicians and Surgeons of Ontario, 2002, p.3). At the moment the current set of programs and policies in the province fall short of these basic criteria.

APPENDICES

Figure 1:
Ontario's Projected Population 1971 – 2031 (in millions)



ACAATO Archive Documents, *2006: Environmental Scan, Section 2 – Demographics*, (Toronto: Colleges Ontario, 2001), p.6.

Table 1:
Ontario Demographic Factsheet

	Intercensal Estimates		Postcensal Estimates						
	1991	1996	2001	2002	2003	2004	2005	2006	2007
POPULATION (000s)									
Canada	28,031	29,611	31,021	31,373	31,676	31,995	32,312	32,649	32,976
Ontario	10,428	11,083	11,898	12,102	12,263	12,420	12,565	12,705	12,804
Ontario as % of Canada	37.2	37.4	38.4	38.6	38.7	38.8	38.9	38.9	38.8
Ontario Ave. Annual Growth Rate *(Over previous year shown)*	2.0	1.2	1.4	1.7	1.3	1.3	1.2	1.1	0.8
AGE DISTRIBUTION (%)									
0-4	7.0	6.8	6.0	5.8	5.6	5.5	5.4	5.3	5.3
5-14	13.1	13.5	13.5	13.4	13.2	13.0	12.8	12.5	12.2
15-24	14.5	13.2	13.4	13.4	13.5	13.5	13.5	13.6	13.6
25-44	34.2	32.9	31.5	31.3	30.9	30.6	30.2	29.8	29.4
45-64	19.6	21.3	23.2	23.6	24.1	24.6	25.2	25.8	26.3
65-74	7.0	7.3	7.0	6.9	6.9	6.8	6.8	6.8	6.9
75+	4.6	5.0	5.6	5.7	5.8	5.9	6.0	6.1	6.3
SELECTED AGE GROUPS (%)									
0-14	20.1	20.3	19.4	19.1	18.8	18.5	18.2	17.8	17.5
15-64	68.3	67.4	68.1	68.3	68.5	68.7	69.0	69.2	69.3
65+	11.6	12.2	12.5	12.6	12.6	12.8	12.8	13.0	13.2
REGIONAL DISTRIBUTION(%)									
GTA	42.0	43.0	44.6	45.0	45.3	45.7	46.0	46.4	46.8
Central	22.2	22.1	22.1	22.0	21.9	21.9	21.8	21.7	21.6
Eastern	13.8	13.8	13.5	13.4	13.4	13.3	13.2	13.1	13.0
Southwestern	13.7	13.4	13.0	12.8	12.7	12.7	12.5	12.4	12.4
Northeastern	5.8	5.4	4.8	4.7	4.6	4.6	4.5	4.5	4.4
Northwestern	2.3	2.4	2.1	2.0	2.0	2.0	1.9	1.9	1.9

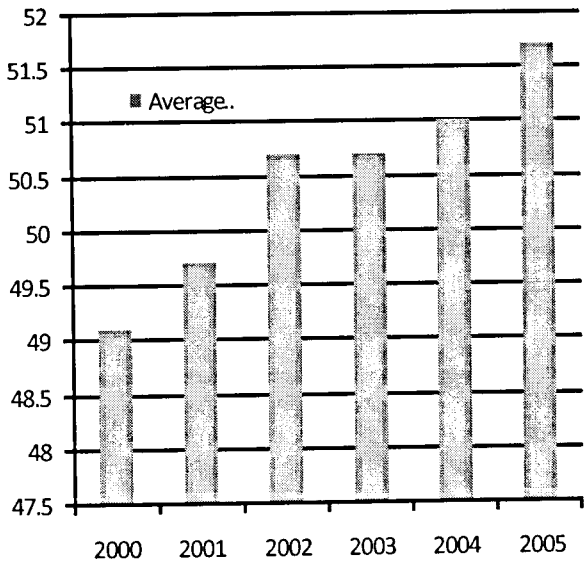
Source: Statistics Canada, *2006 Census – Ontario*, (available from Office of Economic Policy, Labour and Demographic Analysis Branch).

Table 2:
Highest Education Level Achieved by Ontario Immigrants versus the Non-Immigrant Population, Aged 25-44

Education Level	Ontario non-immigrant population, 2001	Arrived between 1991-1995	Arrived between 1996-2001
Less than high school graduation certificate	14.7%	18.6%	11.3%
High school graduation certificate	14.9%	14.1%	9.5%
Some postsecondary education	11.8%	11.7%	7.5%
Trade certificate or diploma	11.3%	8.4%	5.5%
College certificate or diploma	23.4%	16.2%	10.5%
University certificate or diploma below Bachelor's	1.4%	4.2%	5.5%
University degree, of which:	22.4%	26.9%	50.2%
Bachelor's	16.1%	17.7%	29.0%
University certificate above bachelor's degree	2.8%	2.5%	4.9%
Master's	3.2%	5.5%	13.8%
Doctorate	0.3%	1.1%	2.4%
Total Number Aged 25-44	2,438,250	225,230	251,580

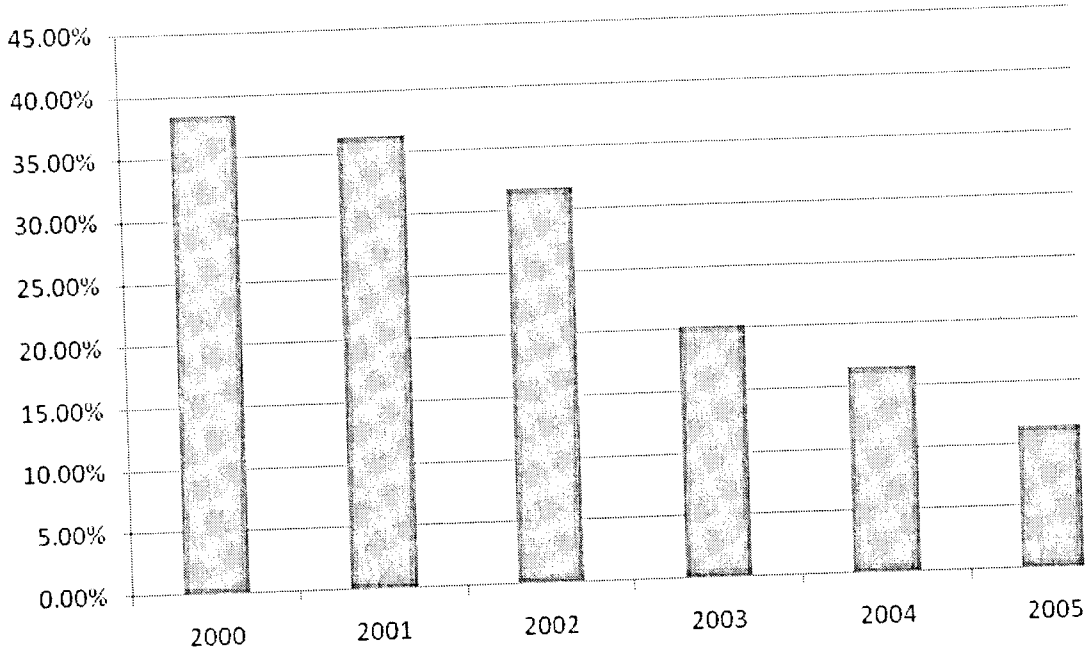
ACAATO Archive Documents, *2006: Environmental Scan, Section 2 – Demographics*, (Toronto: Colleges Ontario, 2001), p.8

Figure 2:
Average Age of Physicians from 2000 – 2005



College of Physicians and Surgeons of Ontario, *2005 Survey of Ontario's Physicians: Access Challenges Ahead*, (Toronto: College of Physicians and Surgeons of Ontario, June 2006), p.2.

Figure 3:
GPs/FPs Accepting New Patients 2000 – 2005



College of Physicians and Surgeons of Ontario, *2005 Survey of Ontario's Physicians: Access Challenges Ahead,* (Toronto: College of Physicians and Surgeons of Ontario, June 2006), p.7.

Table 3:
Percentage of GPs/FPs Accepting New Patients by Postal Code Region

POSTAL CODE REGION	%
Easter Ontario (K)*	4.7
South Central Ontario (L)*	10.6
Toronto (M)*	21.7
Southwestern Ontario (N)*	4.5
Northern Ontario (P)*	10.5
TOTAL	**11.4**

* Geographical region by the first letter of the postal code

College of Physicians and Surgeons of Ontario. *2005 Survey of Ontario's Physicians: Access Challenges Ahead,* (Toronto: College of Physicians and Surgeons of Ontario, June 2006), p.8.

Table 4:
Current and Projected Population Share for Ontario, by Region

	2004	2016	2031
Greater Toronto Area (GTA)	45.6%	47.9%	49.5%
Central (Excluding GTA)	21.9%	21.8%	21.7%
Eastern	13.3%	12.9%	12.6%
Southwestern	12.7%	12.0%	11.6%
Northeastern	4.6%	3.8%	3.1%
Northwestern	2.0%	1.6%	1.4%

ACAATO Archive Documents, *2006: Environmental Scan, Section 2 – Demographics*, (Toronto: Colleges Ontario, 2001), p.10.

Table 5:
Association of International Physicians and Surgeons of Ontario: Membership Statistics, April 2002

Country of Origin		
Iran	121	13.9%
India	109	12.5%
Pakistan	96	11.0%
Romania	51	5.8%
China	46	5.3%
Bangladesh	35	4.0%
Russia	33	3.8%
Afghanistan	30	3.4%
Sri Lanka	25	2.9%
Yugoslavia	25	2.9%
Ukraine	23	2.6%
Sudan	16	1.8%
Bosnia	15	1.7%
Somalia	15	1.7%
Iraq	14	1.6%
Colombia	11	1.3%
Burma	10	1.1%
Egypt	10	1.1%
Brazil	8	0.9%
Albania	7	0.8%
Other Members	147	
Info Not Avail.	194	
TOTAL		**1067**

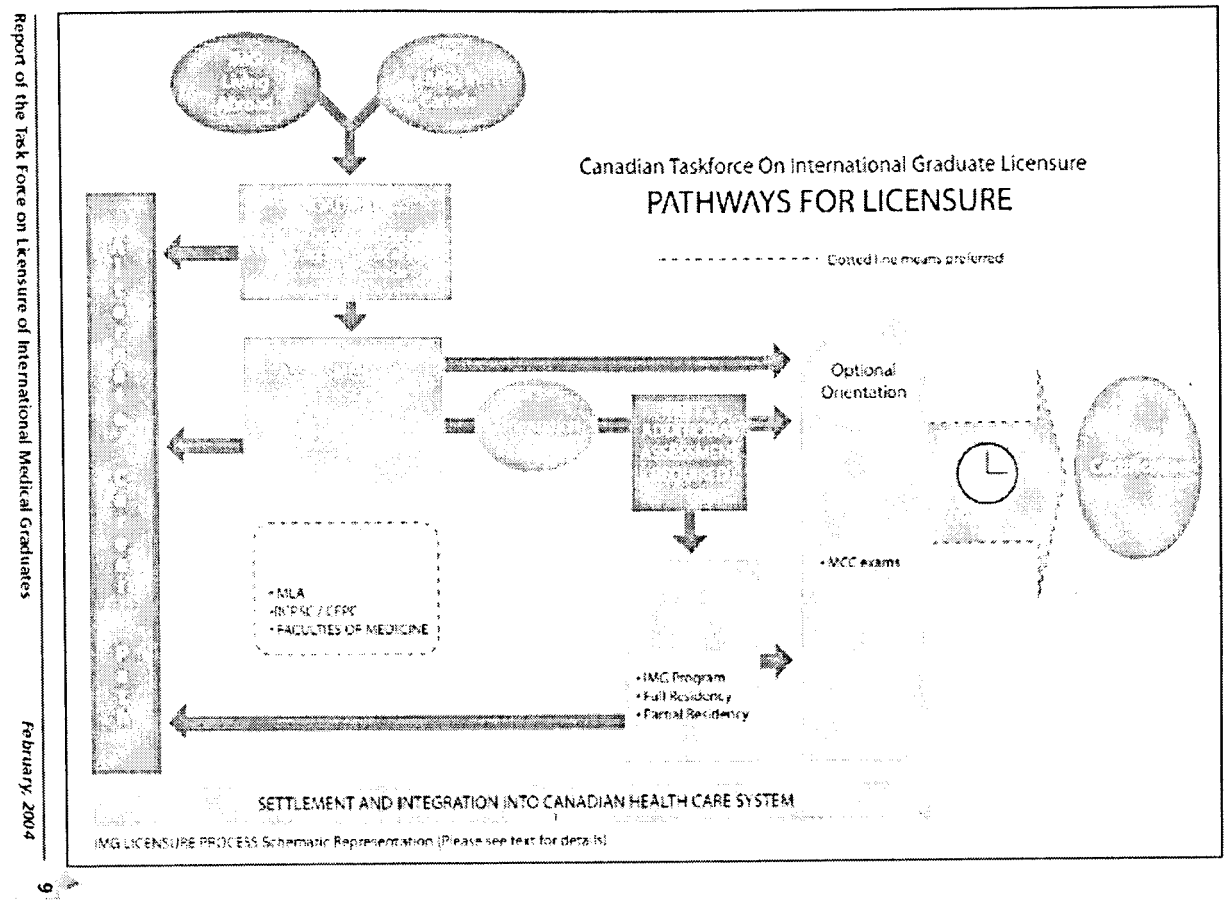
Specialty		
General Practitioner	372	43.9%
OB/GYN	82	9.7%
Pediatrics	40	4.7%
Internal Medicine	37	4.4%
Anesthesiology	34	4.0%
General Surgery	40	4.7%
Radiology	17	2.0%
Pathology	15	1.8%
Dermatology	15	1.8%
Cardiology	15	1.8%
Neurology	14	1.7%
Opthamology	13	1.5%
Psychiatry	12	1.4%
Orthopaedic Surgery	12	1.4%
Epidemiology	8	0.9%
ENT	8	0.9%
Community Medicine	7	0.8%
Tropical Medicine	6	0.7%
Respirology	6	0.7%
Otolaryngology	6	0.7%
Other members	66	
Info Not Avail.	219	
TOTAL		**1067**

Years of Experience as Physicians		
More than 15	156	18.0%
11 to 15	162	18.7%
6 to 10	218	25.2%
1 to 5	329	38.0%
Info. not available	202	
Total	**1067**	

Gender		
Female	431	49.0%
Male	449	51.0%
Info. not available	187	
Total	**1067**	

Association of International Physicians and Surgeons of Ontario, *Integrating Canada's Internationally-trained Physicians: Towards a Coherent, Equitable and Effective National System,* (Toronto: Association of International Physicians and Surgeons of Ontario, May 2002).

Figure 4:
Pathways for Licensure – Canadian Taskforce on International Graduate Licensure



Health Canada, ***Report of the Canadian Taskforce on Licensure of International Medical Graduates,*** **(Calgary: Health Canada, 29Feb – 01Mar 2004), p.9.**

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