

The Role of International Medical Graduates in the Provision of Physician Services in
Atlantic Canada¹

by

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1. Introduction

Physician Shortage

The physician shortage in Canada is acute, and growing. Beginning in the late 1990s, health care human resource planners began to sound the alarm that a shortage existed. In many areas of Canada today, citizens cannot get access to a family physician, because many physicians are not accepting new patients. Furthermore, many rural and remote communities are unable to attract physicians and often those that do relocate do not remain beyond a minimal contractual obligation. According to the College of Family Physicians of Canada, more than 4.2 million Canadians do not have a family doctor¹. In October 2004 it was reported that more than half (60%) of all family physicians either limit the number of new patients they see or do not take new patients at all². As well, only one in four specialists said they could take an urgent referral within 24 hours and almost one third (30%) indicated they would be unable to see even an urgent case within a week of referral.

A 2002 study published by the Canadian Institute for Health Information (CIHI)³ cites several symptoms of the physician shortage: cancelled surgeries, difficulties staffing emergency departments, long waiting lists for specialist services, reports of larger workloads for physicians, and concern over out migration of Canadian physicians to the United States. The forecasts for the near future are that the shortages will worsen, given the increasing health care needs of the country's aging population as well as aging physicians near retirement coupled with a decline in Canadian medical school graduates choosing Family Practice.

There are a number of contributing factors to the physician shortage, many of which are policy-related. The following list details factors which likely contributed to a reduction in physician inflow, according to the 2002 CIHI study:

1. The decision to eliminate the rotating internship
2. The increase in specialty residency positions relative to family medicine
3. Restrictions on international medical graduates (particularly visa trainees)
4. The 5% reduction in medical school enrolment, class of 1991 onwards (small effect)
5. The 10% reduction in medical school enrolment, class of 1997 onwards (small effect)
6. The reduction in the number of retraining opportunities (net short-term *increase* in physician supply)

Source: Chan, BTB. (2002). From Perceived Surplus to Perceived Shortage: What Happened to Canada's Physician Workforce in the 1990s? Canadian Institute for Health Information. Ottawa, ON. Available at: <http://secure.cihi.ca/cihiweb/products/chanjun02.pdf>.

In 1991, upon recommendation from Barer and Stoddard⁴, the Federal government legislated a decrease in medical school enrolment by 10%, which further decreased

supply in Canada. In 1974 enrolment was at its highest of 2,640 and in 1997 enrolment dropped to 1,822, while during this interval, Canada's population grew from 22 million to 30.5 million, thereby adding to demand for more physicians⁵. Medical school enrolment is now increasing but Canada is still not producing enough to meet the need for medical care.

Increasing demands on health care system

There is a shift in demographics in the Canadian population, whereby more (especially) rural citizens tend to be older, therefore in greater demand of physician services. In the 1990s, the Canadian population rose steadily and the proportion who are elderly increased. Since the elderly have greater demand for health services more than younger individuals, there is an increasing need for physician services.

Meeting the demand for and maintaining accessibility to physician services is particularly difficult in Atlantic Canada due to the rural nature of the population and the great distances between communities. Issues around recruitment and retention, core staffing requirements, quality of work-life, and areas of sole practice are stresses to the system⁶. Positions in rural areas may remain vacant for months at a time, and new graduates are sometimes placed in remote locations with little experience and inadequate peer support. Convincing new graduates or experienced professionals to relocate to a rural area is a significant challenge.

One way in which the physician shortage is relieved is through the use of International Medical Graduates (IMGs). An IMG is a physician who has received his or her basic medical training outside of Canada and every Canadian province uses IMGs (although in varying degrees) to make up for the shortfall between the demand for primary health care, and the supply of services by Canadian Medical Graduates (CMGs). The contributions of IMGs to healthcare in this country have been significant. IMGs help contribute to the needs of the supply of health human resources, as Canada has not been able to produce enough graduates to fully meet physician requirements. In 2004, most recent figures indicate that 23% of the physicians practising in Canada received their degree from outside of Canada⁷.

The aim of this paper is to examine this important component of the physician workforce with a particular focus on examining how each province recruits and deploys them and some of the concomitant issues surrounding their on-going retention. The remainder of the paper is organized as follows: Section 2 provides an overview of IMG utilization in Canada. Section 3 explores the trend of IMG migration from rural and remote areas. Section 4 provides a typology of IMGs. Section 5 is a profile of the physician workforce across Canada. Section 6 describes issues pertaining to IMG recruitment among the provinces. Section 7 examines the Atlantic Canadian perspective on IMG use. Section 8 is a discussion on IMG roles in the physician workforce and Section 9 provides some future research directions.

2. IMG Utilization in Canada

Immigration

Historical Perspective: In the 1960s, Canada imported more physicians from countries than it graduated⁸. Physicians were on a so-called “open list” of priority of occupations. However, during the 1970s the government removed physicians from this list which decreased the number of physicians that immigrated to Canada⁹.

Changes to the Immigration Act: The federal government replaced the Immigration Act (originally passed in 1978) with the Immigration and Refugee Protection Act in 2002. The Immigration Act used the General Occupations List (GOL) system, which indicated the occupations which were in demand in Canada. If the applicant’s occupation was not on the list, and the application did not have pre-arranged employment, the applicant was denied entry into Canada¹⁰. Physicians were not on the GOL, therefore under the old system, any person declaring “physician” as their occupation without pre-arranged employment could not enter the country.

The new *Immigration and Refugee Protection Act* removes the immigration restrictions on physicians as an occupational group (GOL), and focuses more on broad-based skills. Several provinces have signed agreements with the federal government which allow for recruitment of professionals in high demand.

Under the old Immigration act, a large number of IMGs did not declare that they were physicians when applying to come to Canada. As a result, their path to integration into the Canadian medical system was difficult. Despite improved access, there are several obstacles to settlement for IMGs entering Canada¹¹:

Barriers to licensing: There is a lack of recognition of credentials and qualifications. Many face difficulties in entering field of prior employment (i.e. specialty).

Economic pressures: The “taxi-driving” doctor phenomenon. IMGs take jobs to support themselves and their families in occupations outside their field of study. Some work in the service industry, for long hours and often work in more than one job.

Language barriers: Barriers to learning English/French include lack of financial resources for language training prior to obtaining employment, and working with others who speak the IMG’s native tongue slows the language acquisition.

Licensing Across the Provinces

A combination of examinations, post-graduate training, language requirements, and assurances of safe medical practice and good conduct are needed to be licensed in Canada. Licensing in Canada is under the jurisdiction of the medical regulatory

authorities in each respective province, which include: the College of Physicians and Surgeons of British Columbia, College of Physicians and Surgeons of Alberta, College of Physicians and Surgeons of Saskatchewan, College of Physicians and Surgeons of Manitoba, College of Physicians and Surgeons of Ontario, College des Medecins du Quebec, College of Physicians and Surgeons of New Brunswick, College of Physicians and Surgeons of Prince Edward Island, College of Physicians and Surgeons of Nova Scotia, and the Newfoundland Medical Board.

Forms of licensing vary slightly by province. Often it is the requirements for post-graduate training that are a stumbling block for IMGs to get licensed in Canada. Some provinces have terms in their licensing requirements that allow IMGs to enter directly into practice via “provisional licensing”. Provisional licenses have conditions, or provisions attached to their issuance. Commonly, these provisions may include: a requirement to have a fully-licensed sponsor or supervisor for a period of time, requirement to practise in an under-serviced area of the province, time restrictions, requirement to complete Canadian medical licensing exams within a defined period. Nomenclature for provisional licenses vary across the provinces, with such licenses being called “public service”, “restricted”, “defined”, “conditional”, or “temporary”, depending on requirements. Licensing differences across provinces are explained in more detail in Appendix A.

A pass on the Medical College of Canada Evaluate Examination (MCCEE) is the first required by IMGs, as a measure of their basic medical knowledge. The MCCEE may be written at locations outside of Canada, including: Paris, France; New Delhi, India; Tokyo, Japan; Muscat, Oman; Riyadh, Saudi Arabia; London, United Kingdom; and Abu Dhabi, United Arab Emirates. From there, successful completion of the Medical College of Canada Qualifying Examination Part I and Part II (MCCQE I and II) are required in order to achieve the Licentiate of the Medical Council of Canada (LMCC) and thus inscription in the Canadian Medical Register.

IMGs do not perform as well as CMGs on qualifying examinations, due to several factors: age (time from medical school until they write the exam), language and cultural issues, and differences in the quality of medical school training. The success rate for Canadian graduates in the three Medical Council of Canada Qualifying examinations is approximately 95% while for IMGs it is 21%¹².

3. IMGs in Rural and Remote Areas

Migration

For many years, IMGs have been used to fill the supply gap for physicians in Canada. In remote and under serviced regions of Canada, medical services provided by IMGs are vital^{13,14,15}. Many IMGs enter the country on funded positions (with regional health boards) and once they attain their licence and/or become a landed immigrant, they leave and migrate to the cities, thereby exacerbating the inequities between access to primary

health care between urban and rural areas¹⁶. Rural areas view a steady stream of IMGs as the only solution to their on-going physician resource problem, however urban areas view this strategy as a “leak” in the system which ends up as an excess supply in specialties and locations which do not necessarily need them¹⁷.

In some provinces, the turnover of IMGs is very high, due to migration to other regions of Canada. Research by the Newfoundland and Labrador Medical Association indicates that 75% of IMGs coming to the province stay for two years, obtain Canadian credentials then move to other provinces, particularly Ontario¹⁸. In NL, there is a constant turnover of about 200 IMGs (of a total of approximately 1000 physicians in active practice in the province) at any given time.

In NL, the retention rate of IMGs is very low. Many IMGs leave “within two years for larger, wealthier provinces, and continuity of care is compromised”¹⁹. The president of the Newfoundland and Labrador Medical Association indicated that many IMGs are turned off in their first few weeks by a variety of factors and many decide to leave after less than three months²⁰. In 2000 the Registrar of the Newfoundland Medical Board stated that about 100 IMGs enter Newfoundland and Labrador every year and the same number leave.

High physician turnover in rural and under-serviced regions are a serious problem in Canada. The relationship with the family (primary care) physician is ideally a long-term one, built upon trust. In situations where the family physician is present in the community for short periods (i.e. two years), it can be argued that a long-term relationship cannot be established, reducing patient satisfaction. Rural areas do not want an uncommitted doctor who will leave after the grant has subsided or the Canadian license is obtained²¹.

4. Typology of IMGs

This section establishes a typology for IMGs that is useful for the purposes of this paper. IMGs can be grouped by immigration status, licensing route, and/or intended practice area among other classifications. The typology below combines these categories based upon the mechanisms and processes through which the IMG enters Canada, how they attempt to get licensed, and what their practise intentions are.

1. Foreign-trained who have Pre-arranged Employment before Entry into Canada and are Granted Provisional Licenses

These IMGs often have not completed post-graduate training in Canada which is required by provincial medical regulatory bodies. Because of this, they may be granted provisional licensure and are hired under temporary employment authorization, which allows them to practice in Canada on the condition being that they can practice only in certain locations for a specified period of time²². Some regional health authorities ask for a return-for-service contract, based upon financial assistance (i.e. interest-free loans) and other financial agreements provided to these IMGs.

Often, regional health authorities in rural, remote, or under-serviced areas issue employ IMGs under temporary employment authorizations. Therefore, IMGs entering the country via pre-arranged work permits are widely dispersed across the country, typically settling in rural and northern regions²³.

2. *Foreign-trained Academics*

Agencies (medical schools, teaching hospitals, or biomedical research institutes) recruit IMGs and must prove to Canadian immigration authorities that no qualified Canadian is available for the position²⁴. This cohort would tend to be awarded some form of provisional licence to practice in a non-clinical setting, in some provinces called “educational licence”.

3. *Foreign-trained who go through CaRMS to get Residencies in Canadian Medical Schools or who participate in Provincial IMG Programs to Access Post-graduate Training*

CaRMS, the Canadian Residency Matching System, is the administrative body which places applicants into Canadian residency programs²⁵. Canadian-trained physicians are permitted to apply to the First Iteration Match positions (i.e. first round), while IMGs are restricted to the Second Iteration Match. The Second Iteration offers applicants positions which were not filled in the first round of competition, and IMGs must compete with former graduates of Canadian medical schools. These former graduates are CMGs who have changed their mind on what type of medicine they wish to practice (i.e. family practice, specialty), and wish to obtain a new residency position.

In an average year, approximately 1,400 Canadian medical school graduates participate in the First Iteration Match, while 700 applicants compete for the approximately 200 positions available in the Second Iteration Match. A group of IMGs recently took legal action against the Manitoba government regarding their application to take part in the first iteration of the Canadian Residency Matching System (CaRMS)²⁶.

Crutcher, Banner, Szafran and Watanabe (2003) surveyed IMGs entering the second iteration of CaRMS²⁷. They found that most were between 30 and 44 years old, and before coming to Canada, 42.8% had practised medicine for 1–5 years and 45.6% had practised for 6–20 years. More than half (54.6%) had completed their medical education in English. Most (69.3%) had done postgraduate training outside Canada. The top 5 choices of clinical discipline in Canada were family medicine/general practice (45.6%), internal medicine (14.9%), surgery (7.3%), obstetrics (6.7%) and pediatrics (4.8%).

4. *Foreign-trained Landed immigrants*

IMGs immigrate to Canada through family reunification programs, refugee programs, or Provincial Nominee programs, among others. Members of this group often make their homes in larger multicultural urban communities. Not all IMGs seek employment as physicians, and not all are successful at obtaining a licence. Licensing barriers sometime

force this group into working in jobs unrelated to their education and training. In its consultations, the Canadian Task Force on IMG Licensure found that the majority of underemployed IMGs enter Canada as landed immigrants and seldom have prearranged employment²⁸.

In the mid 1970s the number of physicians entering Canada as landed immigrants decreased from approximately 1,000 to about 261 in 1979. The figures varied in the 1980s and 1990s, with a range of 200 to 500 physicians per year, and peaks of 462 in 1982 and 525 in 1992. The numbers of physicians entering with landed immigrant status decreased for the period between 1992 and 2000²⁹.

5. Canadian-born who Complete Medical Education Abroad

As a consequence of the decrease in enrolment at Canadian Medical schools in the 1990s, some Canadians began seeking medical education outside Canada. Unfortunately, not a lot is known about this type of IMG. This cohort often applies (with little success) to the CaRMS match, and if rejected completes a residency program in the US³⁰. In recent years, much has been written by and on behalf of this group pleading for easier entry back into the Canadian medical system³¹.

Some provinces have seen organized groups of IMGs form associations. For example, the Association of International Physicians and Surgeons of Ontario (AIPSO) is a non-profit, professional association which represents physicians and surgeons trained and licensed in jurisdictions outside Canada whose mission is to ensure that internationally-trained physicians are integrated effectively and equitably into the Canadian health care system³². Other, more informal alliances of IMGs exist, often through Internet websites and chat forums. Many of these websites criticize the Canadian structures and policies for immigration and licensing.

5. Profile of the Physician Workforce Across Canada

Discussion

Reliance on licensed IMGs for the provision of medical services varies across the provinces. Two main types of licenses are issued to IMGs: full licenses and provisional licenses. Physician databases in Canada such as the Canadian Medical Directory (CMD) keep accurate records of the number of fully-licensed IMGs in the country. The cohort of provisionally-licensed IMGs, however, is more difficult to quantify and characterize.

Therefore, many of the figures presented by physician workforce stakeholders that represent Canada's reliance on IMGs have been underestimated. To investigate this hypothesis, a profile of Canada's physician workforce in 2003-2004 was constructed. Some of the statistics used to construct this profile are not ideal, owing to the circumstances surrounding obtaining data collection. In order to obtain the number of provisionally-licensed IMGs in Canada for 2003, it was necessary to contact the medical

regulatory (licensing) authorities for each province. When providing the number of provisionally-licensed IMGs, some of the provincial medical regulatory authorities reported 2004 data, and some figures represented a snapshot in time. Some medical regulatory authorities do not keep data on the provisional licence register readily available. The medical regulatory authorities keep their medical registers in different format (i.e. electronic database, paper file, etc.) and a standardized, province-wide software program is not used. Furthermore, according to several medical regulatory authorities, data from these medical registers is expensive, difficult, or time-consuming to retrieve. Note that some data from the province of Alberta was not included in this profile. Use of these imperfect figures was unavoidable, due to the reliance on outside sources.

It has been widely agreed upon that IMGs represent approximately 23% of all licensed physicians in Canada. However, this number does not accurately portray the variations between provinces, nor the proportion of IMGs practising under provisional licences. Using data gathered from the CMD and the provincial medical regulatory authorities, 26.1% of physicians practising in Canada in 2003 were IMGs. The differences among provinces were striking (See Table 1).

Table 1: *Fully and Provisionally-Licensed IMGs, by Province*

	BC	AB	SK	MB	ON	QC	NB	PE	NS	NL
% IMG	24.6	25.1	45.8	21.6	18.3	7.5	16.5	31.1	26.0	44.4
% Provisional*	7.7	10.3	17.1	4.0	1.0	0.4	9.9	20.3	8.2	23.0
% Full*	16.9	14.8	28.7	17.6	17.2	7.0	15.5	10.8	17.8	21.4

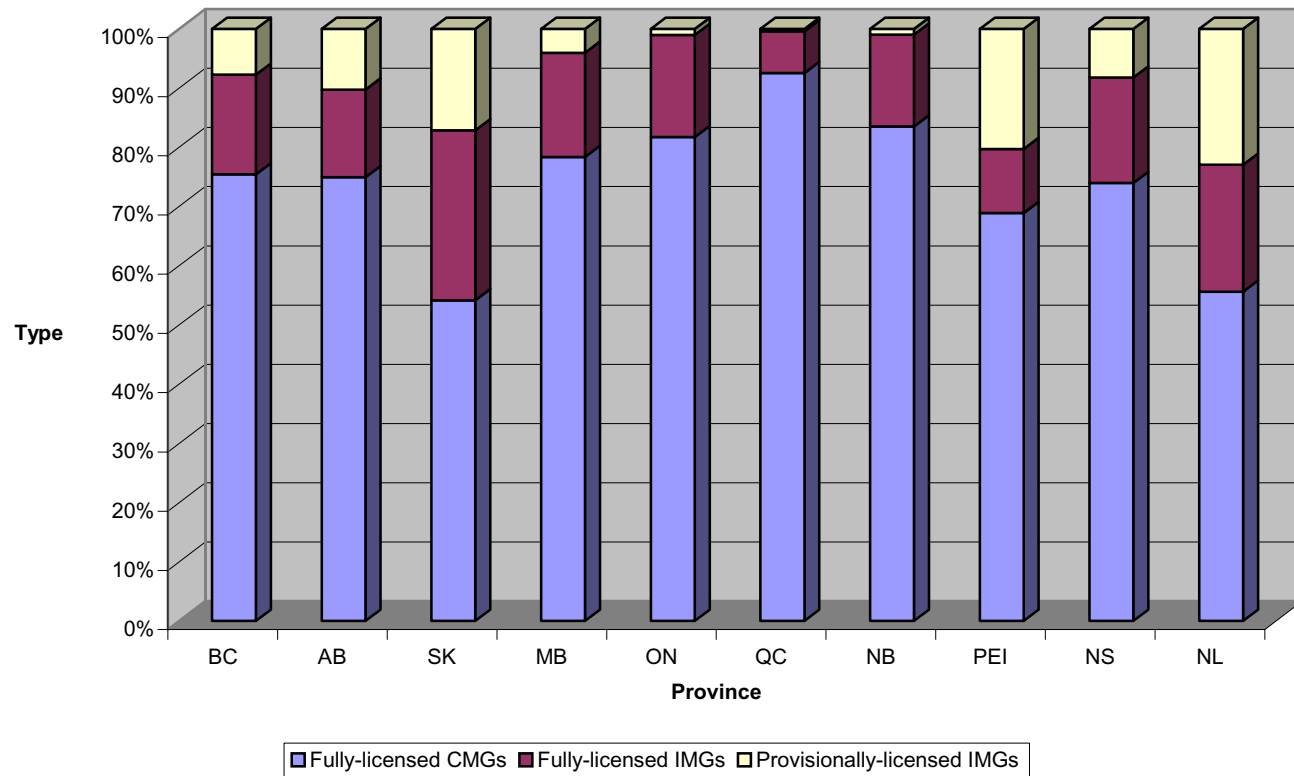
*=Figures may not total due to rounding

A graph was constructed to illustrate a profile of the physician workforce in 2003 (See Figure 1). Figure 1 illustrates a trend, showing decreased usage of IMGs in the central part of Canada, and heavier reliance towards both coasts. Provinces with a high proportion of IMGs included: Saskatchewan (45.8%), Newfoundland and Labrador (44.4%), and Prince Edward Island (31.1%). Those with a low proportion include: Quebec (0.4%), Ontario (1.0%), and Manitoba (4.0%). Usage of IMGs varies greatly by province and region. For instance, a physician recruiter from rural Newfoundland and Labrador stated that in his/her regional health board, 65% of the physician workforce are IMGs (i.e. both provisionally and fully-licensed). Newfoundland and Labrador has a (similarly) high proportion of provisionally and fully-licensed IMGs (23.0% vs. 21.4%).

An average of 13.1% of Atlantic Canada's physician workforce was provisionally-licensed, compared with 6.8% for the six provinces outside the Atlantic Canada, and 9.8% in Western Canada. Overall, the provinces with the highest reliance on the provisionally-licensed IMG cohort was in Newfoundland and Labrador (23.0%), Prince Edward Island (20.3%), and Saskatchewan (17.1%). Prince Edward Island has a significantly higher proportion of provisionally-licensed IMGs than fully-licensed (20.3% vs. 10.8%).

Provinces with have a high proportion of fully-licensed IMGs include: Saskatchewan (28.7%), and Newfoundland and Labrador (21.4%). There are also a large number of provinces which have a significantly higher proportion of fully-licensed IMGs than provisionally-licensed IMGs: British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia. There may be number of reasons for this, including: these provinces may be a popular area of immigration/migration for those IMGs who achieved a full license in Canada, and/or that these provinces may have successful IMG licensing structures.

Figure 1 - Canadian Physician Workforce



6. IMG Recruitment

Provincial Physician Recruitment Profile

Using primary and secondary data, the physician recruitment practices of the provinces in Canada were summarized (Please see Table 1). Four out of nine provinces³³ studied give evidence that they actively recruit IMGs to work in their province: Saskatchewan, Manitoba, Ontario, and Newfoundland and Labrador. Interestingly, in Atlantic Canada only one of provinces (Newfoundland and Labrador) actively recruits, and correspondingly, it has a higher percentage of provisionally-licensed IMGs than the other Atlantic Canadian provinces (See Figure 1).

A survey was conducted with thirteen physician recruiters across Canada, to determine provincial practices, policies, and initiatives for recruiting, deploying, and retaining IMGs. Physician recruiters from three out of the four Atlantic provinces frequently referred to their province's reliance on IMGs in the medical workforce, especially in rural and remote areas. Several of the Atlantic Canadian physician recruiters commented on the challenges facing those involved in the process of employing IMGs in the current system. For example, due to licensing requirements in Nova Scotia, IMGs are often recruited to go to rural areas, where there are more opportunities for local physicians to sponsor (supervise) IMGs. Some Atlantic Canadian physician recruiters commented on the high turnover among IMGs, owing to migration to other parts of Canada: "*Some IMGs move West after 3-5 years here and they have earned a full licence*", "*In some of the more remote areas in the province, IMGs have been hired with the knowledge that the physician may not remain in the province for more than one year on a contract basis.*"

The stakeholders involved in recruitment of IMGs vary across provinces. The departments of health (sometimes in conjunction with the provincial agency representing the regional health authorities) in each of the Atlantic provinces have a centralized physician recruitment office which coordinates recruitment activity at the provincial level. Several of the provinces have an IMG program, which serves as the assessment body for IMGs wishing to gain certain forms of licensure (British Columbia, Alberta, Manitoba, and Ontario). Most of these IMG programs offer forms of post-graduate training, which eases licensing issues, but prolongs entry into practice by one to two years. Therefore, many physician recruiters attempt to hire those IMGs who are eligible for provisional licenses. One province has a dedicated physician/health professional recruitment agency (British Columbia), which serves as the provincial government's recruitment branch, and works closely with regional health authorities and municipalities to meet physician needs.

Recruitment Methods

Each province uses a variety of methods to recruit physicians. Many IMGs are referred to provinces by word-of-mouth, while others obtain information through websites.

Recruitment Agencies: Headhunters (a.k.a. recruitment agencies) are commonly employed by regional health authorities to meet an urgent need or to fill positions which have been difficult to recruit for. Common fees for the recruitment of a FP/GP is \$7,500-\$10,000, and this figure is higher for Specialists.

Word-of-mouth: Much of the recruitment of IMGs is through word-of-mouth. IMGs who enter Canada and succeed in obtaining licensure tend to refer former colleagues from their former country to particular provinces or regional health boards. When word-of-mouth was the recruitment tool used, many regional health authorities will try to place friends together in the same community or area.

Advertisements on Websites and Medical journals: Most provinces have websites which serve as the primary source of information about becoming employed in their respective province. Advertisements are placed in electronic media such as physician recruitment websites and medical journals in certain countries. For example, in the November 1998 issue of the South African Medical Journal there were 23 pages of employment ads and 11 of these pages were from Canada, UK, New Zealand, and Australia.

Inter- and Intra- Provincial Competition: Seemingly, the provinces compete against each other for physician recruitment (of both Canadian-trained physicians and IMGs). Given the high turnover of IMGs in some provinces, some provinces are more involved in active recruitment than others. In addition, regional health authorities within provinces are often aiming to recruit from the same groups of physicians, and there is often a strain placed on the provincial physician recruitment office to equally allocate new recruits to regions.

Table 2: *Provincial Physician Recruitment Summary*

Province	Recruitment Issues
British Columbia	<ul style="list-style-type: none"> • <i>Active Recruitment of IMGs:</i> No • <i>Recruitment Stakeholders:</i> Health Match BC is a recruitment organization funded by the Government of British Columbia whose role is to refer candidates to regional health authorities. Communities within the regional health authorities are heavily involved in the recruitment process. • <i>Website:</i> Health Match BC, Ministry of Health Services, and the individual regional authorities have recruitment webpages. • <i>Immigration:</i> Health Match BC provides assistance with immigration and relocation matters. • <i>Recruiter's Perspective:</i> "We encourage locums in order for the IMG to try out the area, and determine whether they want to relocate".
Alberta	<ul style="list-style-type: none"> • <i>Active Recruitment of IMGs:</i> No. The Alberta IMG Program serves as an entry point. • <i>Websites:</i> Each of the regional health authorities have webpages. • <i>Financial Compensation and Low Taxes:</i> In 2001 the province needed to recruit 1000 physicians over five years, launched a recruitment campaign that enticed physicians on the basis of fees that were among Canada's highest and tax rates that were the lowest. The difference in compensation between Alberta and a province like Newfoundland and Labrador at that time was 30-40%.
Saskatchewan	<ul style="list-style-type: none"> • <i>Active Recruitment of IMGs:</i> Yes. • <i>Word-of-mouth</i> • <i>Website:</i> The Department of Health, and the individual regional authorities have recruitment webpages. • <i>Promotional Strategy:</i> Print advertisements in Canadian Medical Association Journal, Journal of the American Medical Association, and British Medical Journal. • <i>Contact with Medical Students:</i> Physician recruiters hold meetings and recruitment sessions with students at the medical school. • <i>Assistance with Immigration and Licensing:</i> Physician recruiters assist IMGs with applying and obtaining a work permit, and the immigration process. Recruiters also set up appointments and assist with transportation arrangements for licensing through the CPSS. • <i>Acclimatization:</i> All new physicians to the province (not only IMGs) are given an orientation. A volunteer assists new hires with obtaining housing • <i>Financial Incentives:</i> Commonly-used in SK. Some regions have advertisements in foreign medical journals for a \$25,000 practice establishment grant for rural areas. • <i>Retention:</i> Some recruiters hold a voluntary meeting with all new hires 6-12 mths after their arrival, whereby the arrival process is reviewed, and needs assessed. Exit interviews are conducted, and a forwarding address is requested. • <i>Recruiter's Perspective:</i> "...we have some physicians who use our province as an entry point and once they have completed their return for service commitment and all licensing commitments they choose to relocate to larger and warmer centers."
Manitoba	<ul style="list-style-type: none"> • <i>Recruitment Stakeholders:</i> Physician Recruitment Coordinator at the Regional Health Authorities of Manitoba, regional health

	<p>authorities</p> <ul style="list-style-type: none"> • <i>Active Recruitment of IMGs:</i> Yes. • <i>Website:</i> The Department of Health, Regional Health Authorities of Manitoba, and the individual regional authorities have recruitment webpages. • <i>Word-of-mouth</i> • <i>Contact with Practising Physicians:</i> Only those IMGs who have met the CPSM licensing eligibility criteria. • <i>Use of Outside Recruitment Firms</i> • <i>Assistance with Immigration:</i> The Physician Recruitment Coordinator at the Regional Health Authorities of Manitoba in cooperation with the regional health authorities assist IMGs with the immigration process. • <i>Clinical Skills Assessment:</i> All physicians whose medical degrees are not from Canada or the U.S. must satisfactorily complete a clinical assessment as part of the CPSM's eligibility for licensure.
Ontario	<ul style="list-style-type: none"> • <i>Active Recruitment of IMGs:</i> In Southern regions, IMGs tend to contact recruiters. In northern regions, IMGs are actively recruited. • <i>Rural vs. Urban Recruitment:</i> Urban recruiters recognize that their regions are often more cosmopolitan and therefore more attractive to IMGs due to the abundance of multicultural groups, shopping, and cultural experiences available. • <i>Website:</i> The Ontario Ministry of Health, Ontario IMG Program have a website, as do the individual regional health authorities. • <i>Word-of-mouth</i> • <i>Promotional Strategy:</i> Electronic-based advertisements are placed on websites such as Physicianjobsearch.com. Print advertisements in The Medical Post. • <i>Acclimatization:</i> Some regions will put IMGs from the same country in contact with each other. Some municipalities have a Community Relations Co-ordinator who provides assistance with relocation issues, including spousal support, housing, and education, child care. • <i>Deployment:</i> The IMG's country of origin and spouse's education are considered in many regions during the process of hiring. • <i>Incentives for Under-serviced Communities:</i> <ul style="list-style-type: none"> o Community Assessment Visit Program covers costs of tour of community (economy flight, car rental hotel for physician & spouse) from points Montreal west, and Winnipeg east. o Under-serviced Area Program offers \$15,000 over 4 yrs to GPs/FPs or psychiatrists who move to an under-serviced community in southern Ontario, \$40,000 to GPs/FPs or psychiatrists who move to an under-serviced community in northern Ontario, and \$20,000 to Specialists who move to northern Ontario. o IMGs using Ministry programs are (in some regions) offered an interest free loan of up to \$10,000 over a maximum 2 yr period to assist them with start-up and family needs. • <i>Retention:</i> In some areas, once physicians are hired they are given surveys, taken to dinner, telephoned, etc. to follow-up on the level of satisfaction. Exit interviews are conducted on physicians who leave. • <i>Recruiter's Perspective:</i> "Often, IMGs are concerned that they will blend in to the local medical community, and whether they

	<p>will get patients coming to see them”.</p> <ul style="list-style-type: none"> • <i>Recruiter’s Perspective:</i> “The (IMGs) who come to our hospital/community have all stayed. • <i>Recruiter’s Perspective:</i> The Return-of-Service (ROS) is for five years. I have no indication that (the IMGs) will leave when their ROS is complete. Most seem content and settled permanently with their families...IMGs have not left for the past three years.” • <i>Recruiter’s Perspective:</i> “We encourage the spouse to attend the community visit as they are a large part of the decision-making process for where the family will settle.”
Quebec	*Data to follow
New Brunswick	<ul style="list-style-type: none"> • <i>Active Recruitment of IMGs:</i> No. • <i>Website:</i> Department of Health has a physician recruitment webpage, as do the regional health authorities. • <i>Language:</i> In NB, ability to speak French required in some areas, which sees some IMGs come from French-speaking nations. • <i>Promotional Strategy:</i> Advertisements in various publications and electronic media. • <i>Pre-employment Site Visits</i> • <i>Recruiter’s Perspective:</i> “One regional health authority had a physician from South Africa land at the airport late on a Saturday night in the middle of a snowstorm, wearing a polo shirt and shorts, and had no arrangements for a place to stay. This physician called the recruiter, who drove to the airport to pick the physician up and find him/her temporary accommodations and some winter clothing.” • <i>Recruiter’s Perspective:</i> “Some IMGs move West after 3-5 years here and they have earned a full licence. There are various reasons for leaving: 1. they want to be closer to family. 2. they want to do more research, and want to be closer to academic institutions 3. there’s not enough volume of patients in their area to earn their desired income.”
Prince Edward Island	<ul style="list-style-type: none"> • <i>Active Recruitment of IMGs:</i> Yes. • <i>Strategy:</i> Department of Health has a 4-year Enhanced Physician Recruitment Plan, launched in 2000. • <i>Website:</i> Department of Health has a physician recruitment webpage, as do the regional health authorities. • <i>Sponsorship in Clinical Programs:</i> PEI does not have an assessment and training program, but have sponsored IMG applicants to attend programs in other provinces in the past. Approximately 5% of PEI’s IMG applicants have been sponsored, which entails covering costs of the airfare, accommodations, and assessment program fee. • <i>Matching:</i> Physicians recruited to the province are given information on activities that may be of interest to spouses, and information pertaining to the presence of religious, ethnic, or cultural groups is provided. • <i>Recruiter’s perspective:</i> “...continuity of care has always been a priority. In some of the more remote areas in the province, IMGs have been hired with the knowledge that the physician may not remain in the province for more than one year are hired on a contract basis...Although this is not the preference in these locations, the reality of family physician shortages has resulted in the hiring of IMGs in some of the remote locations in the province.”
Nova Scotia	<ul style="list-style-type: none"> • <i>Active Recruitment of IMGs:</i> No. One physician recruiter stated: “In the most part they come to us”. • <i>Website:</i> Department of Health has a physician recruitment webpage, as do the regional health authorities. • <i>Source of IMGs:</i> Many IMGs who come to NS had already been living in Canada for a period of time, and have begun to adapt to

	<p>the “Canadian” way of life</p> <ul style="list-style-type: none"> • <i>Word-of-mouth</i> • <i>Promotional Strategy:</i> Advertisements in various publications and electronic media • <i>Pre-employment Site Visits</i> • <i>Recruiter’s Perspective:</i> “The majority of IMGs go to rural areas where there is more opportunity for sponsorship.”
Newfoundland and Labrador	<ul style="list-style-type: none"> • <i>Active Recruitment of IMGs:</i> Yes. • <i>Strategy:</i> If the IMG meets the criteria for exams, language, training, etc. they can be issued a provisional licence or full licence to practice relatively quickly. If the IMG does not meet all of these criteria but can do so in a six month period, he can be sent to the Clinical Skills and Assessment Training and then be eligible for a provisional licence. • <i>Website:</i> Department of Health has a physician recruitment webpage, as do the regional health authorities. • <i>Contact with Medical Students and Residents:</i> Physician Recruitment Office stays in contact with and liaises with students at the MUN medical school throughout their education. Contact is made with residents in the U.S. and Canada. • <i>Contact with Practising Physicians:</i> E-mails are sent, recruiters travel to medical conferences. • <i>Physician Database:</i> Recruiter maintains records of physicians and medical students. In addition MD Select, a national electronic database provides demographic and employment information. • <i>Promotional Strategy:</i> Electronic-based advertisements are placed on websites such as Physicianjobsearch.com, and MedConnexions.skillnet.ca. Mail-out advertisements are sent to physicians in the U.S., as well as electronic mail to alumni of Memorial University of Newfoundland medical school. Limited number of print advertisements are placed in medical journals abroad. Sometimes, NL uses the natural beauty of the province as it’s sell, promoting practicing among the “craggy cliffs, deep fjords and snow capped mountains. • <i>Use of Outside Recruitment Firms:</i> Many regional health authorities use head-hunters, with minimum charges of \$7500. • <i>Special Treatment from Community:</i> Anecdotal evidence suggests that measures from other stakeholders are undertaken to attract and retain physicians in rural areas: <ul style="list-style-type: none"> o Municipal council paying property tax for the medical clinic o Members of local community providing property maintenance on physician’s home and clinic (i.e. shovelling snow from driveways) • <i>Pre-employment Site Visits</i> • <i>Recruiter’s Perspective:</i> “...we as a people in small communities are finding it difficult to orient, welcome, nurture new physicians and their families so often. Perhaps this is another area that could be studied. I think we can no longer take it for granted that a community will do this repeatedly; and we are at risk of these very important retention issues not being addressed consistently.”

Countries from which Practising IMGs Immigrate

In the past, a large number of Canadian physicians were recruited from Commonwealth nations, particularly the UK, South Africa, and Australia as well as Ireland. This trend of recruiting from Ireland and Commonwealth Nations has ceased, likely due to changes in licensing requirements. Under previous licensing regimes, physicians from Commonwealth countries often met the requirements for post-graduate training, and licensing was straightforward. Evidence suggests that in light of increases in salary in Ireland and the UK, IMGs from these countries are less eager to come to Canada.

More recently, there has been an increasing number of IMGs entering from Asian, Middle Eastern and African countries. Provincial medical regulatory authorities were surveyed to determine the most common countries of origin for provisionally-licensed IMGs (See Figure 2, Table 2 and Table 3). Note that the inconsistencies in data described in Section 5 (i.e. some provinces providing 2004 data) apply here as well.

Among provisionally-licensed IMGs across Canada in 2003, there was a substantial trend among the most common countries of origin. The most frequent country was India (among the most common in eight provinces), followed by South Africa (six provinces), Egypt (five provinces), Pakistan (four provinces). See Figure 2, Table 1, Table 2.

Physician recruiters have seen an increase in IMG applicants from Middle Eastern and African countries. For example, in Newfoundland and Labrador, applications for employment are received from Saudi Arabia, Afghanistan, Libya, Egypt, Iran, and Nigeria. In Atlantic Canada, India was common in all four provinces, Egypt was common in three out of four Atlantic provinces, and South Africa and Pakistan were common in two Atlantic provinces.

Country of origin, amongst other characteristics of IMGs entering Canada, is a grossly understudied area of health human resources. With further data on where IMGs are coming from, policy-makers and all stakeholders will be better equipped to study trends, plan, and manage IMG issues. For example, Health Canada states that IMGs from the Middle East, Asia, and Africa, may require much more in-depth clinical skills assessment and additional training as compared to IMGs from other regions³⁴.

The cohort of fully-licensed IMGs across Canada was not studied, and trends among countries of origin for this group may be different since they are likely to have been in Canada for a longer period of time. In addition, very little is known about the cohort of IMGs who are presently in Canada, but are not practicing. This might change, however, since organizations representing practicing and non-practicing IMGs are beginning to form (e.g. Association of International Physicians and Surgeons of Ontario). These organizations are lobbying on behalf of IMGs, and will likely influence and create the impetus for research into IMG characteristics.

There are ethical concerns surrounding the recruitment of physicians from other countries, given the worldwide shortage of healthcare professionals. A significant proportion of IMGs are from developing countries. The High Commissioner of South

Africa appealed to provincial health ministers in Canada to stop recruiting their physicians³⁵. Canada has signed an ethics agreement with other Commonwealth countries to stop recruiting doctors from developing nations³⁶. Although Canada is actively recruiting IMGs, many others come of their own volition and they have the freedom to choose the country to which they want to immigrate. Canada must take measures not to actively recruit physicians from developing countries³⁷.

Despite the obvious ethical conflicts, a report by CIHI on Physician Shortages states that physicians coming to Canada are coming from developing nations such as South Africa, which declare to have major physician shortages themselves^{38,39,40}. In 2001, South Africa's high commissioner to Canada issued an unprecedented appeal to provincial and federal ministers of health ministers, requesting that they stop recruiting South African physicians⁴¹.

Figure 2: Five Most Common Countries of Origin for Provisionally-licensed IMGs

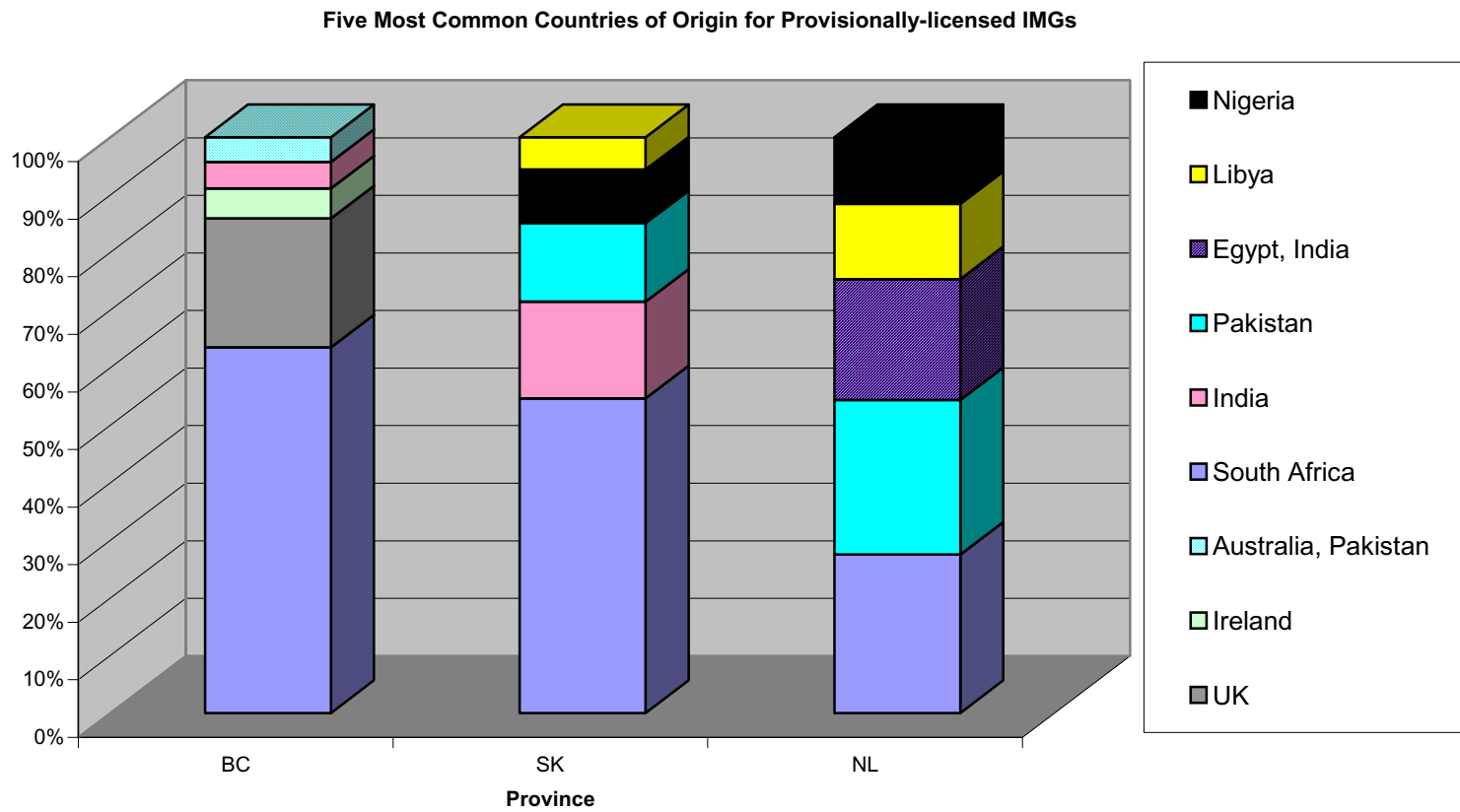


Table 2: *Five Most Common Countries of Origin for Provisionally-Licensed IMGs*

	MB	QC	NB	NS
1	South Africa	France	Philippines, India	Egypt
2	Greece	Belgium	Egypt, Nigeria, Dominican Republic, Belarus, Jordan, Cameroon	India
3	USSR	Brazil	X	Sri Lanka
4	India	Lebanon	X	Poland
5	Iran	Egypt	X	Iraq

Table 3: *Most Common Countries of Origin for Provisionally-licensed IMGs*

ON	PE
UK, India, South Africa, Egypt, Russia	Pakistan, India, South Africa, Ireland, UK, Hong Kong, Greece, Ireland, Antilles, Jamaica, France, Tanzania, Columbia, Bangladesh

7. The Atlantic Canadian Perspective

While the focus of this study has been to provide an overview of the use of IMGs across Canada, the main theme of this section is to highlight the main themes surrounding IMG recruitment and utilization in Atlantic Canada.

Physician recruitment and particularly retention are very significant issues in Atlantic Canada and this is particularly true in rural communities. The economic prospects in these communities are often bleak, the climate can be harsh and the cultural and social opportunities for a peer network of physicians is limited. Recent research in Newfoundland and Labrador suggests the integration of IMGs' spouses into these communities plays a critical role in determining long term retention⁴². Rural Atlantic Canada appears to be a 'tough sell' for physicians recruiters, with IMGs tending to prefer more urban settings and provinces with a stronger multicultural base (in particular BC and Ontario). Further, Atlantic Canadian physicians tend to be among the lowest paid in the country, which makes it difficult for this region to provide financial incentives to compete. This appears to have resulted in a more liberal licensing policy in this region

vis a vis more affluent provinces who report being much more selective in their licensing policies.

The use of provisionally licensed IMGs tends to be more common in Atlantic Canada than elsewhere in the country. For many IMGs practicing under this arrangement, Atlantic Canada is not the first location choice, but offers an expedient path to obtain full licensure. A freshly credentialed physician is in considerable demand in the labour market and Atlantic Canada needs to do a better job at retaining these highly skilled individuals. This process needs to begin with a recruitment and deployment strategy that attempts to fit individuals with communities where they are apt to stay. In addition, a long term retention strategy needs to be put in place to increase the likelihood that IMGs will remain in the region.

8. Discussion

Throughout this paper we have examined the role that IMGs play in providing physician services – often in communities that have difficulty attracting a doctor. In many cases, particularly in Atlantic Canada, these individuals gain the right to practice through a provisional license. The standards and guidelines for awarding provisional licenses vary from province to province, but the anecdotal evidence suggests that obtaining a provisional license is relatively easier in Atlantic Canada – in particular Newfoundland and Labrador. As described earlier, the main objective for IMGs practicing using a provisional licence is to obtain a full licence. Indeed, they are offered significant support from their employers to reach this objective.

However, this creates an on-going problem for many regional health authorities in Atlantic Canada. As individuals receive their full licenses they become mobile within Canada and many doctors seize this opportunity to relocate within Canada. This results in an on-going problem for many communities since they face regular and rapid turnover of physicians. In effect, once they obtain their mobility through a full license, they have a high likelihood of joining the long-standing tradition of skilled individuals leaving Atlantic Canada for better career prospects in Central and Western Canada.

This is a particularly worrying trend for two main reasons. First, recruiting a new physician, particularly from abroad is expensive. If regional health authorities are required to replace physicians every two years (which is typically the amount of time necessary to obtain a full license) this means a considerable outlay of financial resources, that would be more efficiently spent on the actual provision of health care. Also, as was noted earlier, patient satisfaction is, at least, partly a function of developing a long-standing relationship with a physician. This becomes far more difficult when the physician serving that community only remains in a position for a relatively short period. In short, a high turnover rate results in more expensive, and potentially less satisfactory, care.

9. Implications and Future Research

In this study we review how IMGs take up practice in Canada, paying particular attention to policies towards recruitment, licensing and deployment. Some provinces appear to have more liberal policies towards licensing and are viewed as a natural ‘entry point’ for IMGs who are seeking provisional licenses as a means to obtain a permanent credentials that will allow them to practice anywhere in the country. This adds to the long-standing tradition of skilled Atlantic Canadian workers moving to more prosperous parts of the country. In essence, Atlantic Canada (and particularly Newfoundland and Labrador) are subsidizing the medical training of IMGs who eventually relocate.

This focuses our future research to understanding retention issues among IMGs and particularly those operating on provisional licenses, since these are a particularly mobile component of the physician labour market. We intend to focus on understanding what are the factors that contribute to a provisionally-licensed IMG migrating from Atlantic Canada with a focus decomposing how their demographic or family circumstances contributed to the decision to migrate; how good a ‘fit’ they were for their community and practice; and whether additional steps could have been taken by the regional health authorities or other institutions to facilitate their retention.

From a more Canadian perspective, there remains an on-going problem of credential recognition for professionals from many foreign countries. Developing a comprehensive plan to recognize the credentials of highly skilled (and under utilized) immigrants would alleviate skill shortages across many occupational categories, including physicians.

APPENDIX A: PROVINCIAL LICENSING PROFILE

Full Licensure

PROVINCE	STANDARDS FOR FULL LICENSES	POST-GRADUATE TRAINING	OTHER
British Columbia	<ul style="list-style-type: none"> • Be graduates in medicine from a university or medical school approved by council • LMCC • Satisfy the registrar that they are permanent residents of British Columbia or that their taking up permanent residence in British Columbia is imminent. 	<ul style="list-style-type: none"> • Satisfactory completion of 2 years of <i>accredited and approved</i> postgraduate training with a basic core of 44 weeks consisting of 8 weeks in each of Medicine, Surgery, Obstetrics/Gynaecology, and Paediatrics, and 4 weeks in each of Psychiatry, Emergency Medicine, and Family/General Practice. <u>One</u> of the two years must be <u>in</u> Canada, if not a Canadian graduate • Satisfactory completion of 2 yrs of <i>accredited and approved</i> postgraduate training with a basic core of 44 wks consisting of 8 wks in each of Medicine, Surgery, Obstetrics/Gynaecology, and Paediatrics, and 4 wks in each of Psychiatry, Emergency Medicine, and Family/General Practice, and five yrs practice in British Columbia on the Temporary Register and a satisfactory assessment by the College of Physicians and Surgeons of B.C. 	
Saskatchewan	<ul style="list-style-type: none"> • LMCC <u>Specialists</u> 	<ul style="list-style-type: none"> • Successfully completed a 24-month residency in family medicine 	

	<ul style="list-style-type: none"> Completed a residency in a specialty in a Canadian training program AND certification with the Royal College of Physicians and Surgeons of Canada, AND have attained the LMCC 	in Canada	
Alberta	<ul style="list-style-type: none"> Ability to communicate in one of Canada's official languages An approved North American medical school, or a school of medicine that is listed in the directory of the world health organization and has carried on a medical education program for more than 10 years and offers a medical training program of at least 48 months in duration Licentiate of the Medical Council of Canada (LMCC) and; certification from the College of Family Physicians of Canada (CCFP) or the Royal College of Physicians and Surgeons of Canada 	<ul style="list-style-type: none"> Approved training necessary in order for the physician to be eligible to write the LMCC, CCFP or Royal College examinations 	<ul style="list-style-type: none"> Canadian citizen, landed immigrant, or employment authorization/work permit from the Canadian government Immediately be proceeding forthwith into the practice of medicine in Alberta Of good character and reputation, that your name has not been struck off a register of any licensing authority and that you are not or have not been suspended by any licensing authority or tribunal in Canada or elsewhere
Manitoba	<p>One of:</p> <ul style="list-style-type: none"> LMCC specialist certificate from the Royal College of Physicians and Surgeons of Canada obtained by examination Specialist certification obtained through an examination administered by the College des Medecins du Quebec <p>AND one of:</p> <p>(A)satisfactory completion of the certification requirements of the</p>	Acceptable post grad training: An "approved university teaching program" means a program of postgraduate training approved by the Federation of Medical Licensing Authorities of Canada Accreditation Committee, or the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada, or a program with a major university affiliation as listed in the American Medical Association Directory of Graduate Medical Education Programs or in	

	<p>College of Family Physicians (B) Royal College certification (C) Specialist certification or family medicine certification obtained through an examination administered by the College des Medecins du Quebec (D) Satisfactory completion of postgraduate clinical training: for those applying for registration in primary care (general practice), a two-year postgraduate clinical training program acceptable to the College. The program must be an approved university teaching program containing a core of eight weeks in general medicine, eight weeks in general surgery, eight weeks in obstetrics, and eight weeks in paediatrics. For those applying for registration in a specialty field of practice, current certification from a member board of the American Board of Medical Specialties which would entitle the physician to obtain a licence limited to the specialty training field</p>	<p>the Directory of the Council of Teaching Hospitals.</p>	
<p>Ontario</p>	<ul style="list-style-type: none"> • Must obtain a Certificate of Registration Authorizing Postgraduate Education, AND a Certificate of Registration Authorizing Independent Practice • Requirements for Certificate of Registration Authorizing Independent Practice: <ol style="list-style-type: none"> 1) A medical degree from an 	<ul style="list-style-type: none"> • For both a family practitioner or specialist, IMGs must have all the Canadian postgraduate qualifications required for an Independent Practice certificate. There are two ways to do this: <ul style="list-style-type: none"> • Obtained after graduation with a medical degree from an accredited medical school in North America or 	

	<p>accredited Canadian or U.S. medical school or from an acceptable medical school listed in the World Directory of Medical Schools.</p> <p>2) MCCQE I and II</p> <p>3) Certification by examination by either the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC)</p> <p>4) Completion in Canada of one yr of postgraduate training or active medical practice, or completion of a full clinical clerkship at an accredited Canadian medical school</p> <p>5) Canadian Citizenship or permanent resident status <i>*this can be exempt, if all other requirements are met</i></p>	<p>an acceptable medical school outside of North America. The College does not recognize any non-Canadian alternatives to these qualifications</p> <p>OR</p> <ul style="list-style-type: none"> • Complete the Ontario IMG Program in order to access post-graduate training 	
<p>Quebec</p>	<ul style="list-style-type: none"> • Completed their period of post-grad training in a manner satisfactory to the Faculty of Medicine and the Collège des médecins du Québec (CMQ) <p><u>Family Medicine</u></p> <ul style="list-style-type: none"> • Successfully passed all three components of the examination in family medicine: MCC component Objective Structured Clinical Examination, qualifying examination, part II; College of Family Physicians of Canada component Short Answer Management Problems Simulated Office Oral; CMQ component Objective Structured Clinical Examination) as well as the ALDO- 		<ul style="list-style-type: none"> • Must have a working knowledge of the French language

	<p>Québec examination (Legislative, Ethical, and Organizational Aspects of Medical Practice in Quebec)</p> <p><u>Specialists</u></p> <ul style="list-style-type: none"> • Successfully pass the specialty exam, as well as the ALDO-Québec examination. The specialty examination varies by discipline. Either an oral, clinical, and practical exam specific to the CMQ, and/or comprehensive Objective Examination, shared with the Royal College of Physicians and Surgeons of Canada 		
New Brunswick	<ul style="list-style-type: none"> • Either certified in Family Practice by the College of Family Physicians of Canada OR Physicians certified in a specialty by the Royal College of Physicians and Surgeons of Canada or the College of Physicians of Québec 	<ul style="list-style-type: none"> • Hold the LMCC AND have at least one yr of training in an accredited Canadian or American program, generally be in the form of a rotating internship 	<ul style="list-style-type: none"> • Physicians otherwise eligible for licensure in the Province of Quebec • In limited circumstances, physicians eligible for licensure in the State of Maine
Prince Edward Island	<ul style="list-style-type: none"> • e-mailed 		
Nova Scotia	<ul style="list-style-type: none"> • Be graduates in medicine from a university or school of medicine approved by Council • LMCC 	<ul style="list-style-type: none"> • Certification of the College of Family Physicians of Canada or certification of the Royal College of Physicians and Surgeons of Canada, or any other postgraduate diploma held • 2 yrs training consisting of: <ul style="list-style-type: none"> A) basic component: 12 wks of Family Medicine or Emergency Medicine, and at least 8 wks of General Surgery, Internal Medicine, 	<ul style="list-style-type: none"> • must be Canadian citizens or satisfy the Registrar that they are legally entitled to live and work in Canada • must be able to communicate in English to the satisfaction of the Registrar • if have not held a licence previously, a Certificate of Good Conduct and Professional Competence may be required from the last hospital in which they held/hold an appointment • may be required to have a personal

		<p>Paediatrics, Psychiatry and Obstetrics and Gynaecology (B) elective component: minimum of 8 wks in any one discipline and a maximum of 24 wks in any discipline other than Family Medicine, Internal Medicine, Paediatrics, or Emergency Medicine, the maximum for which is 52 wks</p> <ul style="list-style-type: none"> • if the applicant is not a Canadian graduate, one of the 2 yrs of postgraduate training must be done in Canada 	interview with the Registrar, Credentials Committee, or Council
Newfoundland & Labrador	<ul style="list-style-type: none"> • Completed the entire course of studies required by, and holds a medical degree or diploma in medicine from, a university, college or school of medicine or surgery recognized and approved by the Board <p><u>Specialists</u></p> <ul style="list-style-type: none"> • Completed a course of training which has been accepted by the Royal College of Physicians and Surgeons of Canada as being adequate for admission to examination for certification in a specialty of medicine and who, following examination, has been granted a fellowship or equivalent diploma or degree by a college which in the opinion of the board is equivalent to the Royal College of Physicians and Surgeons of Canada 	<ul style="list-style-type: none"> • completed internship or residence training that may be required by the Board 	

Provisional Licensure

In most provinces, the LMCC is required. If the IMG does not have the LMCC, some form of provisional license may be granted.

PROVINCE	TYPE OF PROVISIONAL LICENCE	POST-GRADUATE TRAINING	OTHER
British Columbia	<u>Temporary License</u> <ul style="list-style-type: none"> • Graduates of an approved WHO medical school, and in practice during last 3 yrs • Guaranteed location with a sponsoring regional health authority • Clinical supervisor who is ideally in the same community • Must pass the MCCEE within 1 yr, and MCCQE Part II within 3 yrs 	<ul style="list-style-type: none"> • Two yr entry to practice educational program with the core subjects of: medicine, surgery, obstetrics, paediatrics, family medicine, psychiatry, emergency medicine • 2nd yr may be acceptable if performed in community service as long as there is adequate on-site supervision and affiliation with a post-graduate program 	<ul style="list-style-type: none"> • Family physicians whose training is not acceptable may apply to the IMG Program at UBC, which has 6 postgraduate positions. • Specialists without R.C.P.S.C. certification may be considered for temporary registration in an underserved area of need. The requirements for full registration are deferred, not waived
Alberta	<u>Special Registration</u> <ul style="list-style-type: none"> • Immediately intend to practice medicine in Alberta • Satisfy the registrar of the ability to communicate in one of Canada's official languages • Physicians who have been out of practice for three years or more must undergo assessment and upgrading before they may be considered eligible for licensure • Geographic restriction: specified community with medical need • Approved North American medical school, or a school of 	<u>Special Registration</u> <ul style="list-style-type: none"> • For family physicians, 24 mths of approved training including a minimum of 8 wks each of pediatrics, internal medicine, surgery, obstetrics and gynecology, psychiatry, emergency medicine and 12 wks of family medicine • For specialists, Canadian-equivalent specialty training (as determined by the registrar or, if specialist recognition is required, by the Council) 	<u>Alberta IMG Program</u> <ul style="list-style-type: none"> • The Alberta International Medical Graduate Program (AIMG) selects and prepares IMGs for postgraduate training. Eligible applicants go through a clinical skills assessment, and then a ranked list of eligible individuals is generated from a summative review to establish the successful applicants who will proceed to the clinical experience portion of the program. Short listed AIMG candidates are selected for the available AIMG-sponsored postgraduate residency positions in Family Medicine at University of Alberta and at University of Calgary. 2005 will be the first year that postgraduate training in specialty disciplines will be offered

	<p>medicine that is listed in the directory of the world health organization and has carried on a medical education program for more than 10 yrs and offers a medical training program of at least 48 mths in duration</p> <ul style="list-style-type: none"> • Licentiate of the Medical Council of Canada (LMCC) • Alberta sponsor (i.e. regional health authority) • Preliminary Assessment • Supervised integration into practice in Alberta <p><u>Provisional Practice</u></p> <ul style="list-style-type: none"> • Geographic restriction to an area of medical practice designated as having an emergency requirement by the Minister of Health • Time limitation of 30 mths • Approved North American medical school, or a school of medicine that is listed in the directory of the world health organization and has carried on a medical education program for more than 10 years and offers a medical training program of at least 48 mths in duration. • MCCEE • Alberta sponsor (i.e. regional health authority) • Preliminary Assessment 	<p><u>Provisional Practice</u></p> <ul style="list-style-type: none"> • Medical training that prepares the physician for independent practise in Alberta: • For family physicians: preference is given to those candidates with at least 24 mths of approved training including a minimum of 8 wks each of pediatrics, internal medicine, surgery, obstetrics and gynecology, psychiatry, emergency medicine and 12 wks of family medicine 	<p>through the AIMG program. These postgraduate residencies are exterior to the CaRMS match. The AIMG program is funded by the Alberta Government of Alberta</p>
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	<ul style="list-style-type: none"> Supervised integration into practice in Alberta 	<ul style="list-style-type: none"> For specialists: preference is given to those candidates with specialty certification from a country with a similar healthcare system 	
Saskatchewan	<p><u>Full licensure</u></p> <ul style="list-style-type: none"> (Royal College certification for physicians with specialist credentials, all the required postgraduate training for family physicians and the three MCCE examinations for all physicians) within a defined time schedule May practice on a temporary license for a period of time before being required to commit on a longer-term basis to practice in Saskatchewan, or to practice in a particular Saskatchewan community. Must commit to a defined period of practice in a Saskatchewan community as a condition of obtaining such a license Ensure that physicians working on a temporary license have a named physician who is responsible to assist the physician in becoming aware of Saskatchewan practice issues <p><u>Provisional license for family physicians</u></p> <ul style="list-style-type: none"> Either full licensure with the country in which their training was taken or a pass standing in the MCCEE 		<p><u>Pilot Saskatchewan IMG Project</u></p> <p>The College of Physicians and Surgeons with the co-operation and assistance of the College of Medicine and the Government of Saskatchewan established a pilot project in 2002 to assess the skills and knowledge of physicians to practice as family physicians in Saskatchewan. If selected the IMG is required to attend at their cost the Clinicians Assessment and Enhancement Program (CAPE) in Winnipeg, Manitoba, may be required to attend at a rural physician site for up to six months for further evaluation following the CAPE assessment, and will be required to agree that, if they are licensed by the College of Physicians and Surgeons of Saskatchewan, they will practice in an area of need in Saskatchewan for 3 yrs</p> <p><u>Special licenses for:</u></p> <ul style="list-style-type: none"> Certification-eligibility with the Royal College of Physicians and Surgeons of Canada, and who have achieved full licensure in their country of training, FLEX or USMLE Step 3

	<ul style="list-style-type: none"> • Commitment to remain in a named Saskatchewan community for 3 yrs • Must write the MCCEE at the next opportunity and must pass the MCCEE within 2 yrs. Must pass the MCCQE Part I within 4 yrs and must pass the MCCQE Part II within 5 yrs <p><u>Provisional licenses for specialists</u></p> <ul style="list-style-type: none"> • Eligible with the Royal College of Physicians and Surgeons of Canada • Commitment to remain in a named Saskatchewan community for 3 yrs • Must obtain Royal College certification within the period of Royal College certification-eligibility (usually 3 yrs) and must obtain the LMCC within 5 yrs • Psychiatrists to work for the Government of Saskatchewan, a district health board or the Regional Psychiatric Centre • Oncologists who have been offered a position by the Saskatchewan Cancer Agency if a special request is made by the Minister of Health • Medical Health officers who have been offered a position as a 	<p><u>Provisional license for family physicians</u></p> <ul style="list-style-type: none"> • 24 months of approved postgraduate training 	
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	<p>Medical Health Officer by a district health board, who have a Masters degree in public health from a program recognized in Saskatchewan and for whom a special request is made by the Saskatchewan Minister of Health</p> <ul style="list-style-type: none"> Physicians who are not certification eligible with the Royal College but who meet other defined criteria. There must be an unmet need for the physician's services that cannot be met by a Royal College certified or certification-eligible physician 		
Manitoba	<p><u>Conditional Registration</u></p> <ul style="list-style-type: none"> Be a graduate from an approved Faculty of Medicine Have satisfactorily completed an assessment process acceptable to the College Hold an unexpired pass standing in the MCCEE (or are a graduate of a Canadian or U.S. medical school), or Part I or Part II, or both (LMCC) of the MCCQE Be issued a certificate from the Minister of Health stating that the physician is required to provide medical services in a specified community or practice setting Exceptions on the above are granted when the applicant meets the following criteria: is eligible for 	<p><u>Conditional Registration</u></p> <ul style="list-style-type: none"> (A) two years postgraduate clinical training acceptable to the College, which includes a core of eight weeks each of general medicine, general surgery, obstetrics and gynaecology, and paediatrics, which took place in one or more health care facilities affiliated with an approved faculty of medicine whose faculty are on-site, and which provided supervision and formal evaluation by the teaching staff, and is recognized for the purposes of registration in which the clinical training was completed <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> one yr postgraduate clinical training acceptable to the College which meets the requirements as 	<ul style="list-style-type: none"> The Medical Licensure Program for International Medical Graduates (MLPIMG) allows for licensure of primary care physicians IMGs may apply to the Faculty of Medicine, University of Manitoba for an assessment to determine if they have the medical knowledge and skills required for licensure in Manitoba. The process includes written and oral examinations as well as a clinical assessment using the Clinicians Assessment and Professional Enhancement (CAPE) process Those who complete the assessment with satisfactory results and who meet all other requirements for conditional registration may apply to the College of Physicians and Surgeons of Manitoba to determine their eligibility for conditional registration. They will have up to 5 yrs to

	<p>examination by one of the American Specialty Boards based on satisfactory completion of training, or is a Diplomate of an American Board of Medical Specialty, OR is eligible for examination in a specialty of the Royal College of Physicians and Surgeons of Canada based on satisfactory completion of residency training, OR is eligible for examination by, or is a certificand of, the College of Family Physicians of Canada</p>	<p>outlined in (A) and have had a total of at least 3 yrs practice experience in the preceding 5 yr period and complete an orientation program acceptable to the College</p> <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • The highest qualification in a specialty field where the length of training is of equal duration to that required by the Royal College of Physicians & Surgeons of Canada, which would entitle the physician to obtain a licence limited to the specialty training field <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • two years of postgraduate clinical training acceptable to the College which meets the requirements as outlined in (A) and a postgraduate training program acceptable to the College which would entitle the physician to obtain a licence limited to the specialty training field 	<p>complete the Medical Council of Canada Qualifying Examinations</p> <ul style="list-style-type: none"> • During that period the IMG will practise in an underserved area of the province (as declared by the Minister of Health) with a medical practice advisor who will provide support and guidance to the individual
<p>Ontario</p>	<p><u>Ontario IMG Program</u></p> <ul style="list-style-type: none"> • IMG Ontario is the entry point through which IMGs in Ontario can gain access to the qualifications for independent practice. It is both a resource centre and a gateway into residency programs leading to RCPSC or CFPC certification • Candidates are selected based on the outcomes of various screening measures and criteria. Selected IMGs are then offered positions in residency programs in 	<p><u>Ontario IMG Program</u></p> <ul style="list-style-type: none"> • The Ontario IMG Program offers access to post-graduate training 	<p><u>Registration through Practice Assessment (RPA)</u></p> <ul style="list-style-type: none"> • RPA is a new pilot project funded by the Ontario Ministry of Health and Long-Term Care to assess IMGs who have extensive practice experience outside of Ontario. This assessment program was developed as part of a larger strategy to find practical solutions to the doctor shortage in Ontario • The RPA process is designed for doctors with experience and in active medical practice in a jurisdiction outside

	<p>Ontario or in pre-residency clerkships. These programs all lead to RCPSC or CFPC certification and, ultimately, to eligibility for an independent practice certificate of registration from the College.</p> <ul style="list-style-type: none"> • The Specialist Assessment Program assesses qualified and experienced IMG specialists for their readiness to start specialty practice in Ontario, without prior completion of a Canadian residency program. Selected IMG specialists undergo a six-month assessment, which, if successfully completed, is followed by a five-year period of monitored specialty practice in an under serviced Ontario community. During this 5 yr period, the IMG is expected to pass the MCCQE Parts I and II and the examinations of the RCPSC or CFPC 		<p>Ontario. It allows the applicant who is not certified as a specialist by one of Canada's national colleges to gain access to registration through an evaluation of his or her clinical and practice skills, and can be tailored to the individual applicant. This new "expedited" assessment program focuses on the skills and abilities of an individual doctor rather than looking at grades and training programs</p>
<p>Quebec</p>	<p><u>Restrictive Permit</u></p> <ul style="list-style-type: none"> • Hold a diploma of doctor in medicine from a medical school or university registered in the WHO World Directory of Medical Schools • Provide attestations and proof of good standing with a competent authority and that he is practising or has practised with competence the discipline concerned for a period of 12 mths in the 4 yrs preceding the application • Successfully pass the following examinations: Examination on the 	<p><u>Restrictive Permit</u></p> <ul style="list-style-type: none"> • Provide the necessary attestations, such as certificates and diplomas demonstrating that the candidate interested in obtaining a restrictive permit has completed the training necessary to acquire the competence in the area for which he is requesting a restrictive permit 	<p><u>Restrictive Permit</u></p> <ul style="list-style-type: none"> • Prove that his or her services meet an obvious need in a discipline or region and are required by an establishment • Serve an evaluation period whose duration is determined by the CAE-CET, usually 3 mths, in an establishment affiliated with a university and accredited by the CMQ, in the discipline concerned • Evaluation period report submitted to the CAE-CET at the mid-point and at the end of the period

	<p>legislative, ethical and organizational aspects of medicine as practised in Québec (ALDO-QUÉBEC), AND MCCEE, or the United States Medical Licensing Examination/Step 2, CK (Critical Knowledge), (USMLE/Step 2) or the standard certificate of the Educational Commission for Foreign Medical Graduates (ECFMG), AND Examination on knowledge of the French language of the Collège des médecins du Québec or of the Office québécois de la langue française</p>		
New Brunswick	<p><u>Public Service Licence</u></p> <ul style="list-style-type: none"> Eligibility for license under this section shall be determined by a review of the applicant's qualifications by such means as the College deems necessary, which may, without limiting the generality of the foregoing, include: A) evidence of such specialty training and certification as would in the College's opinion, adequately prepare the applicant for the intended practice situation B) a period of assessment within a clinical setting C) evidence of eligibility for licensure in another jurisdiction D) evidence from such other sources as may be available 		<p><u>Public Service Licence</u></p> <ul style="list-style-type: none"> Employment by the Department of Health and Community Services or its equivalent, OR employment by a hospital, institution, commission, regional hospital corporation or similar authority The practice of a member licensed under this section shall be limited to such roles and locales as determined by the employer
Prince Edward Island	<ul style="list-style-type: none"> To be e-mailed 		

<p>Nova Scotia</p>	<p><u>Defined License in Family Medicine</u></p> <ul style="list-style-type: none"> • All candidates must pass one of the following examinations: MCCEE, MCCQE Part I, Education Commission for Foreign Medical Graduates, FLEX, National Board of Medical Examiners, or United States Medical Licensing Examination • Candidates already licensed and practicing for a minimum of one year elsewhere in Canada or the US, and who do not have the examinations noted above must pass the MCCEE prior to being licensed • Candidates with a minimum of one year of licensed practice experience in Canada or the US, or a minimum of one year of training in the US in a school of medicine approved by the Liaison Committee on Medical Education, must have three references from physicians thoroughly familiar with their licensed practice experience or training, and must be interviewed by the Registrar • Candidates with no Canadian or US licensed practice experience or training in the US in a school of medicine approved by the LCME, must be interviewed by the Registrar, and have a formal clinical assessment in a recognized Canadian physician assessment 	<p><u>Defined Licence in Family Medicine</u></p> <ul style="list-style-type: none"> • The post MD licensed practise experience or training outside of Canada or the US must be acceptable to the College 	<p><u>Defined Licence in Family Medicine</u></p> <ul style="list-style-type: none"> • Sponsors must formally report to the College after one month regarding the candidate's performance after close supervision. • Sponsors are required to indicate whether, in their opinion, the candidate is fit to practice medicine • A sponsor will not ordinarily sponsor more than one candidate during any candidates first year of practice. For clarity, after the first year the sponsor may continue to sponsor that physician and sponsor a new candidate for one year • Candidates must pass the Medical Council of Canada Qualifying Exam (MCCQE) Part I within 2 years from the time of receiving the Defined License, and must pass the MCCQE Part II within 2 years after completion of Part I • Candidates must become members of the College of Family Physicians of Canada (CFPC) and become certificant of the CFPC by the practise eligible route within 6 yrs of obtaining the Defined License • If the candidate does not pass the MCCQE Part I, or obtain the LMCC or become a certificant of the CFPC within these time periods the defined license will not be renewed at the next time of the annual renewal
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	program approved by Council		
Newfoundland & Labrador	<p><u>Provisional License</u></p> <ul style="list-style-type: none"> Permitted to practice only within a specific geographical location in the province Must have a sponsor Graduation from a School or Faculty of Medicine, which is recognized by the World Health Organization and which has carried out a continuous medical education program for more than ten years, during which it offered and continues to offer, a medical training program that is of at least 48 mths duration may be required to have satisfactorily completed the MCCEE 	<p><u>Provisional Licence</u></p> <ul style="list-style-type: none"> Satisfactorily completed a minimum of one year postgraduate training acceptable to the Medical Board <p><u>Specialists</u></p> <p>(A) Applicants who have graduated in medicine from an approved faculty or school of medicine and who have completed a minimum of four years of postgraduate training in the speciality in Canada, the United States of America, the United Kingdom, the Republic of Ireland, Australia, New Zealand or the Republic of South Africa. Such applicants may be required to have passed a specialist higher qualification examination administered by a medical authority responsible for specialist training in the country where the applicant completed postgraduate training</p> <p>OR</p> <p>(B) Applicants who have completed four years of postgraduate training whose postgraduate training has been accepted by the Royal College of Physicians and Surgeons of Canada as providing eligibility to take the certification examination of the College. Applicants are responsible for the submission of their postgraduate training to the Royal College of Physicians and Surgeons of</p>	<p><u>Provisional Licence</u></p> <ul style="list-style-type: none"> Valid for one year May require a reasonable fluency in the English language, by obtaining a computer based score of 237 in TOEFL (Test of English as a Foreign Language) and a score of 50 in TSE (Test of Spoken English) <p><u>Clinical Skills and Assessment Program (CSAT)</u></p> <ul style="list-style-type: none"> Applicants applying for a licence for entry to general practice who are assessed as ineligible may be eligible to enter CSAT which has been developed by the Faculty of Medicine at Memorial University of Newfoundland. Satisfactory completion of CSAT will fulfill the clinical training requirements and enable the applicant to continue the application process for a provisional licence

		<p>Canada for assessment. Confirmed eligibility to take the certification examination will be basis for the Medical Board's consideration of eligibility for entry to specialist practice. Any enquiries regarding the process of assessment of your postgraduate training by the College should be directed to the College</p> <p>OR</p> <p>(B) Applicants who have completed three years of postgraduate training in internal medicine, pediatrics or emergency medicine in the United States of America in a program accredited by the Accreditation Council on Graduate Medical Education and who acquired by examination board certification in one of these specialties from the appropriate American Board</p>	
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