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ONE STEP FORWARD – TWO STEPS BACK? A DISCUSSION PAPER ON PHYSICIAN MOBILITY IN CANADA

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Preface

The Royal College of Physicians and Surgeons of Canada is a national, not-for-profit organization that oversees the medical education in 61 specialties and subspecialties in Canada by setting high standards for postgraduate medical education and continuing professional development. In collaboration with health organizations and government agencies, the Royal College also plays a role in developing sound health policy in Canada. The Royal College is committed to working together for excellence in specialty medicine for healthy Canadians.

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Executive Summary

Governments and regulators are adopting new approaches to address labour and medical workforce shortages, including amendments to the Agreement on Internal Trade (AIT) and establishing international agreements.

In July 2008, provincial and territorial premiers announced amendments to the AIT by January 1, 2009, that allow any worker, including physicians, certified for an occupation by a regulatory authority of one province or territory to be recognized as qualified to practice that occupation by all other provinces and territories. By the summer of 2009, mutual recognition of occupational credentials will exist in all provinces and territories and any exceptions to full labour-market mobility will have to be justified as required to meet a legitimate objective such as the protection of public health or safety.

The provinces have long advocated enhanced labour mobility between jurisdictions within Canada and also internationally, and have pursued separate arrangements containing the mutual recognition of credentials between themselves and also other jurisdictions. This includes the October 2008 recognition of professional qualifications between Quebec and France, with a subagreement between the Collège des médecins du Québec and the Ordre national des médecins de France to provide mutual recognition of professional qualifications for physicians trained in each jurisdiction by June 30, 2009.

In addition, in an effort to reduce barriers to physician mobility, the College of Physicians and Surgeons of Ontario (CPSO) has introduced new alternative pathways to registration. These requirements vary depending on the source of the physician's medical degree, where she or he is currently practicing, and where the applicant received postgraduate training.

The majority of physicians practicing in Canada undergo a similar education and examination process to ensure core competencies. These measures exist to ensure that physicians receive rigorous and systematic assessments, which are key components to assure pan-Canadian standards.

Although the education and examination process for most physicians is similar, there is more variation across Canada concerning their licensure and registration, especially concerning provisional licensure. Provisionally licensed international medical graduates (IMGs) usually must agree to work in an underserviced area for a specific period before qualifying for a full license; after that, they may locate anywhere in Canada. Like their Canadian-trained counterparts, many IMGs gravitate to urban centres upon achieving a full license. This is particularly noteworthy given that some provinces, which rely heavily on provisionally licensed IMGs, may be serving as an initial screening mechanism for other provinces that wish to recruit fully licensed IMGs, allowing them to avoid granting provisional licenses.

While mutual recognition of registration has been sought to address the maldistribution of physicians, remove perceived regulatory barriers to mobility and allow providers to practice where they wish, concern has arisen that the proposed amendments to the AIT may exacerbate physician shortages or workforce maldistribution in certain areas of Canada.

Amendments to the AIT also raise legitimate concerns about the ability of jurisdictions to fulfill their duty of "protecting the public" by severely limiting their ability to ascertain the competency of physicians wishing to move to their respective jurisdictions. These concerns are based on a number of elements, including indications that mutual recognition will apply to provisional licenses as well as full licenses and the need for jurisdictions to demonstrate that additional requirements are not, for example, barriers to mobility instead of legitimate checks and balances in light of variations in education and credentials underlying provisional licenses across jurisdictions within Canada.

Negotiations are underway concerning the Québec-France subagreement on mutual recognition, including a provision that mutual recognition will only apply to those MDs who have been trained in either France or Quebec. Physicians migrating from France will supposedly not be able to use Quebec as a gateway to other jurisdictions within Canada. Licensing authorities in each jurisdiction are supposed to have the right to evaluate and reject any individual applicant under this arrangement. However, given that the ability of regulators to impose additional requirements will effectively be curtailed under the AIT amendments, it is difficult to see how regulators could halt the mobility of French-trained physicians once they arrive here. As well, it is reasonable to conclude that other provincial and territorial jurisdictions will, in effect, be bound to accept the standards agreed to under such international agreements since physicians licensed under these arrangements will subsequently have unfettered mobility according to the AIT's provisions.

The CPSO alternative pathways to registration seek to address physician shortages in this province. While the objective of reducing barriers to licensure of physicians is commendable, serious concerns have been expressed that the proposed new pathways 5 and 6 may have unintended consequences resulting in the erosion of care in Ontario. The Royal College has shared these concerns with the CPSO's registrar. These concerns are based on a number of considerations:

- Standards of mentorship, supervision and assessment are not clearly defined under the proposed new pathways.
- Reliance on an already over-taxed medical workforce to support these pathways for assessments, supervision, mentorship and teaching may result in unintended consequences, such as a negative impact on the training of residents with Canadian postgraduate medical education programs.
- Use of the 29 jurisdictions previously assessed by the Royal College as the basis for acceptance of training may be problematic at this juncture due to the need to review, revise and possibly extend jurisdictional assessment.

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- These changes to registration have the potential to exacerbate longstanding physician migration patterns away from smaller jurisdictions to urban centres within Ontario given that certification is not required.

As these changes to the physician regulatory landscape across Canada unfold, the following questions must be posed:

1. What are the implications for appropriate physician supply across Canada, (geographic distributions and skill mix/type) given that the AIT amendments will extend mutual recognition to those physicians working under provisional licenses? If some provinces already serve as a screening mechanism for other provinces to recruit fully licensed IMGs, will the AIT amendments, possibly coupled with international agreements, exacerbate this trend?
2. Given the AIT amendments, especially as they will pertain to provisional licenses, and the difficulties involved in assessing training programs in international jurisdictions, how can regulators ensure high-quality, safe patient care?
3. With the growing tendency on the part of regulatory authorities to move away from Canadian certification as standards for licensure of medical specialists, what measures, if any, would be appropriate for certifying bodies and other organizations concerned with standards to undertake in order to ensure the provision of safe, quality care by appropriately trained physicians and surgeons?

The Royal College has provided commentary concerning the potential benefits and pitfalls of the amendments to the AIT to federal/provincial/territorial (FPT) Ministers of Health and Labour in a letter sent on December 5, 2008. On the same day, FPT Ministers of Internal Trade approved the text of a Protocol of Amendment to the AIT to actualize these proposed amendments. Subject to respective Cabinet approvals, they will come into force April 1, 2009.

The Royal College will continue to work with partner health organizations and other stakeholders to make its concerns known to FPT governments regarding the potential and unanticipated ill effects of these proposed changes during the implementation period. The College will also help develop measures that will ensure the maintenance of high-quality care for Canadians, including advocating for rigorous evaluation of the results emanating from these changes to the AIT on the provision of timely and safe care in Canada. In addition, the Royal College will also examine its own certification protocols to ensure that the processes by which physicians achieve certification as specialists in Canada keep pace with medical education and training to meet societal health needs.

I. Introduction: A changing physician regulatory landscape in Canada

> Provincial licensing authorities do not apply uniform licensing requirements so that a physician who is competent to practice in one province may be deemed not to be so in another. Licensing fees, required documentation, residency requirements and interviewing requirements vary dramatically from one province to another and can change from year to year. This has made it very difficult for physicians to move about in Canada.
>
> George Magee, MD
> Physician Advocate, Society of Rural Physicians of Canada (2001)[1]

> There is a long history around medical regulation. While admittedly a patchwork nationally, the current system and its regional variations have been created to serve the needs of the population. Let us hope that the premiers do not forget the lessons of the past, and recognize the other social objectives that current licensure requirements attempt to address. Otherwise we may see fewer physicians . . . especially in those areas of the greatest need, rather than more.
>
> Trevor Theman, MD
> Registrar, College of Physicians and Surgeons of Alberta (2008)[2]

In Canada, governments and regulators are adopting new approaches to address labour and medical workforce shortages, including amendments to the Agreement on Internal Trade (AIT), establishing international agreements, and adopting new ways to achieve medical registration for medical graduates whose education and work experience may differ from the majority of physicians who practice here.

The 1995 Canadian Agreement on Internal Trade was supposed to facilitate portable licensure for physicians through the provision allowing "any worker qualified for an occupation in the territory of a Party [i.e., province or territory] to be granted access to employment opportunities in that occupation in the territory of any other Party"[3] by each jurisdiction undertaking to "mutually recognize the occupational qualifications required of workers of any other Party and to reconcile differences in occupational standards." [4]

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1 Society of Rural Physicians of Canada. (May 14, 2001). "Dr Magee Physician Advocate for License Portability." Press Release. Retrieved from http://www.srpc.ca/.
2 College of Physicians and Surgeons of Alberta. (September 2008). "Registrar's Report: AHSA and labor mobility: challenges ahead." *The Messenger*, 145, 10. Retrieved from http://www.cpsa.ab.ca/publicationsresources/attachments_messengers/M145.pdf.
3 Industry Canada. (1995). "Chapter Seven: Labour Mobility." *Agreement on Internal Trade*. Chapter 7, Article 701, 89. Retrieved from http://www.ait-aci.ca/en/ait/AIT%20Original%20with%20signatures.pdf.
4 Ibid., Article 708, 91.

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To comply with earlier commitments to bring all regulated occupations into full compliance with the AIT by April 2009,[5,6,7] in July 2008, the Council of the Federation (the intergovernmental body of provincial and territorial premiers established in 2003) announced amendments to the AIT by January 1, 2009, which "will provide that any worker [including physicians] certified for an occupation by a regulatory authority of one province or territory shall be recognized as qualified to practice that occupation by all other provinces and territories."[8] On December 5, 2008, federal/provincial/territorial (FPT) Ministers of Internal Trade approved the text of a Protocol of Amendment to the AIT to actualize these proposed amendments. Subject to respective Cabinet approvals, they will come into force April 1, 2009.[9] By the summer of 2009, mutual recognition of occupational credentials will exist in all provinces and territories and "any exceptions to full labour-market mobility will have to be clearly identified and justified as necessary to meet a legitimate objective such as the protection of public health or safety."[10]

The provinces have long advocated enhanced labour mobility between jurisdictions within Canada and also internationally, and have pursued separate arrangements containing the mutual recognition of credentials between themselves and other jurisdictions. These include

- the April 2006 Trade, Investment and Labour Mobility Agreement (TILMA) between British Columbia and Alberta;[11]
- the June 2008 commitment by Ontario and Quebec to pursue automatic recognition for professionals;[12] and
- the October 2008 recognition of professional qualifications between Quebec and France, with a subagreement between the Collège des médecins du Québec (CMQ) and the Ordre national des médecins de France to provide mutual recognition of professional qualifications for physicians trained in each jurisdiction by June 30, 2009.[13,14]

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5 The Council of the Federation. (August 10, 2007). "Premiers Strengthen Trade." Press Release. Retrieved from http://www.councilof thefederation.ca/pdfs/Competitiveness_Trade_Aug8_EN.pdf.
6 See also Internal Trade Secretariat. (October 2008). "Chapter 7: Achievements: Labour Mobility." Retrieved from http://www.ait-aci.ca/index_en/progress.htm.
7 See also Betty Vepstas. (Effective Practices Specialist – Labour, Alberta Employment and Immigration). (June 18, 2008). "Agreement on Internal Trade (AIT): Chapter 7 (Labour Mobility) Before and After the April 1, 2009 Compliance Deadline." *PowerPoint presentation* approved by FLMM [Forum of Labour Market Ministers] Senior Officials. Retrieved from http://www.ccls-ccag.ca/files/2008%20-Approved%20DECK%20for%20EXTERNAL%20Consultation%20(2).ppt.
8 The Council of the Federation. (July 18, 2008). "Successful Fifth Annual Summer Meeting for the Council of the Federation." Press Release. Retrieved from http://www.councilofthefederation.ca/pdfs/Cover_communique.pdf.
9 Committee of Ministers on Internal Trade. (December 5, 2008). **"**Progress on Labour Mobility and Dispute Resolution Enforcement." Press Release. Retrieved from http://www.ait-aci.ca/index_en/news.htm.
10 See the Council of the Federation. (July 18, 2008), op.cit.
11 TILMA requires that both provinces "mutually recognize or otherwise reconcile their existing standards and regulations that operate to restrict or impair trade, investment or labour mobility." Article 5, 3. Retrieved from http://www.tilma.ca/agreement/files/pdf/AB-BC_MOU-TILMA_Agreement-Apr06.pdf.
12 Ontario Office of the Premier. (June 2, 2008). "First-Ever Joint Meeting of Ontario and Quebec Cabinets." Backgrounder. Retrieved from http://www.premier.gov.on.ca/news/ProductPrint.asp?ProductID=2279.
13 Collège des médecins du Québec. (October 17, 2008). "The Collège des médecins committed to facilitate the delivery of permits to practice in Quebec for physicians trained in France." Press Release. Retrieved from http://www.cmq.org/CmsPages/PageCmsFunctionnalSplit.aspx?PageID=751ef6a6-8f55-4f52-bfe4-ad31819cdf4e&StatementID=df8bc737-e0d5-46cd-917f-addf97aa5056.

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Regulatory changes are also being implemented in a number of jurisdictions in an effort to reduce barriers to physician mobility. For example, the College of Physicians and Surgeons of Ontario (CPSO) has introduced new alternative pathways to registration. The requirements under these pathways vary depending on the source of the physician's medical degree, where she or he is currently practicing, and where the applicant received postgraduate training. Pathways 1-4 have been approved by the CPSO and came into effect December 1, 2008; pathways 5 and 6 have not yet been approved.[15] The Royal College has discussed the implications of these proposed pathways with CPSO's registrar.

Many physicians and physician organizations have long advocated for portable licensure in this country to lower perceived regulatory barriers to practice that many physicians encounter when they move between jurisdictions. For example, Task Force Two, a partnership of national, provincial and territorial healthcare organizations and governments, called within its 2006 strategy on physician human resources for the development of a "harmonized, pan-Canadian process that ensures that licensure of physicians in every province/territory follows standardized practices," including practicing physicians, medical graduates and international medical graduates (IMGs).[16] Seamless physician mobility between jurisdictions, both within Canada and between Canada and other countries, with concomitant provisions concerning harmonization of medical education, training, licensure and registration, has been advocated as one way to ensure sufficient physician workforce supply in terms of the geographic distribution and the mix and type of available physician skills. This is important not only to meet immediate societal health needs, but also in terms of health human resources (HHR) surveillance, planning and forecasting to ensure a responsive health care system able to meet anticipated future needs and enhance patient outcomes. This will require appropriate changes in physician education and training, including continuing professional development (CPD), licensure and registration, recruitment and retention strategies, and practice patterns and activities.

This paper concerns the complex and multifaceted interplay between physician licensure and registration, and education and training, with a particular focus on how physician mobility may be affected by the AIT amendments, international trade and mobility agreements, as well as recent developments concerning registration in Ontario. In turn, these developments are examined regarding how they may impact physician education and training as well as licensure and registration, and the implications for patient care. This interplay of factors highlights a number of key policy concerns, including the following:

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14 Approximately 45 professional groups will be covered by the Québec-France agreement. The subagreement under the Quebec-France main agreement will include approximately 30 specialties that are the easiest to recognize in terms of equivalencies in training and length of time for study, but this process is not yet complete; approximately another 10 specialties that are among the most difficult in terms of recognition are still being negotiated. The subagreement will contain an annex outlining which specialties are recognized and which are not. Personal communication with Registrar Dr. Yves Lamontagne and Director of Medical Education Dr. Anne-Marie Maclellan, Collège des médecins du Québec. (October 8, 2008).
15 College of Physicians and Surgeons of Ontario. "Alternative Pathways to Registration." Retrieved from http://www.cpso.on.ca/policies/policies/default.aspx?id=2348.
16 Task Force Two. (March 2006). "A Physician Human Resource Strategy for Canada: Final Report." vi-vii, 26-27. Retrieved from http://www.physicianhr.ca/reports/TF2FinalStrategicReport-e.pdf.

1. The appropriate balance between the freedom of individual physicians to migrate and practice where they wish and ensuring appropriate physician supply and the type/mix of physician skills and training to meet societal health needs.
   - How can the latter be achieved without compromising the former?

2. The management of physician mobility in Canada (between provinces and territories and also internationally) to ensure an adequate physician supply to meet societal health needs, while maintaining quality and safety of care.
   - How can the education, training, licensing, recruitment and retention of physicians across Canada be harmonized, and how can barriers toward this goal be addressed?

3. A physician workforce in Canada sufficient in numbers, skills and distribution to meet societal health needs.
   - How can the entry and integration of IMGs into the physician workforce be enhanced while preserving appropriate standards for clinical competencies?

II. Physician Mobility in Canada: A Snapshot

As a critical component of both physician supply and also distribution across Canada, physician mobility encompasses both inter-jurisdictional migration of physicians to and from Canada as well as intra-jurisdictional migration across provinces and territories. Inter-jurisdictional and intra-jurisdictional mobility of physicians include both Canadian-trained physicians as well as IMGs. A snapshot of physician mobility for the period 2003-2007 reveals a complexity of trends concerning physicians who migrate to and from Canada as well between jurisdictions within this country (see Appendix 1).

While several factors influence physician mobility, including when physicians receive their medical degrees, their age, economic developments, public policy decisions and other factors, this paper focuses on physician mobility patterns of Canadian-trained physicians and IMGs and their implications for education, training, licensure and registration as changes in the physician regulatory landscape in Canada unfold.

In terms of inter-jurisdictional physician migration to and from Canada, from 1990 to 2004, Canada consistently lost more physicians through migration abroad compared with those who moved abroad and then returned; small gains only began to appear in 2005 and have since been sustained (see Appendix 2). This change from net loss to net gain is partially the result of more physicians returning from abroad than those leaving for each year from 2003 to 2007; the overall

movement to and from Canada decreased during this period.[17] If serious physician shortages forecasted for the US occur,[18] these gains may be in jeopardy of being lost.

Canada has historically relied upon IMGs, who have comprised approximately 20-30 per cent of the physician workforce,[19] as Dr. W. Dale Dauphinee, former Executive Director of the Medical Council of Canada and Co-chair of the recent Canadian Task Force on the Licensure of International Medical Graduates,[20] has pointed out,

> the percentage of those physicians with employment arranged before coming to Canada also fell during the early 1990s . . . . Do they stay in Canada? The percentage of IMGs who are Canadian-landed immigrants and who move to the United States is thought to be similar to Canadian-trained graduates, again contributing to a net flow away from Canada.[21]

In 2006, all jurisdictions within Canada employed IMGs; the national average within the total physician workforce was 22 per cent[22] (a substantial decline from previous decades[23]), but there were considerable variations between jurisdictions and between family medicine practitioners and other specialists. While all but three jurisdictions (Prince Edward Island, Quebec, and Nunavut) have a lower proportion of IMGs within their physician workforce than the pan-Canadian average, some jurisdictions such as Newfoundland and Labrador, Manitoba, Saskatchewan and the Yukon rely much more heavily on IMGs than other jurisdictions, for both family medicine practitioners and other specialists. (Table 1)

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17 Canadian Institute for Health Information (CIHI). (2008). "Supply, Distribution and Migration of Canadian Physicians, 2007." p. 4. Retrieved from http://secure.cihi.ca/cihiweb/products/SupDistandMigCanPhysic_2007_e.pdf.
18 The Physicians' Foundation. (November 18, 2008). "National Survey Finds Numerous Problems Facing Primary Care Doctors, Predicts Escalating Shortage Ahead." Press Release. The survey results "show the possibility of significantly decreased access for Americans in the years ahead, as many doctors are forced to reduce the number of patients they see or quit the practice of medicine outright." Retrieved from http://www.physiciansfoundations.org/news/news_show.htm?doc_id=728872.
19 Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources. (2004). "Report of the Canadian Task Force on Licensure of International Medical Graduates." p. 1. Retrieved from http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/hhr/medical-graduates.pdf.
20 Ibid.
21 W. Dale Dauphinee. (April 28, 2005). "Physician Migration to and from Canada: The Challenge of Finding the Ethical and Political Balance Between the Individual's Right to Mobility and Recruitment to Underserved Communities." *The Journal of Continuing Education in the Health Professions*, 25 (1), 22–29.
22 CIHI. (2008). op.cit., 117.
23 See Dauphinee, op.cit, 23.

Table 1: Canadian-trained medical graduates and international medical graduates, Canada, 2006[24]*														
P/T	NL	PEI	NS	NB	QC	ON	MB	SK	AB	BC	YT	NWT	NU	CAN
All MDs • CN • IMG	 65% 35%	 86% 14%	 72% 28%	 78% 22%	 89% 11%	 76% 24%	 70% 30%	 51% 49%	 72% 28%	 72% 28%	 69% 31%	 71% 29%	 89% 11%	 78% 22%
FamMed • CN • IMG	 66% 34%	 85% 15%	 73% 27%	 84% 16%	 88% 12%	 78% 22%	 58% 42%	 45% 55%	 64% 36%	 71% 29%	 69% 31%	 66% 34%	 88% 13%	 77% 23%
Specialists • CN • IMG	 63% 37%	 88% 13%	 70% 30%	 72% 28%	 90% 10%	 74% 26%	 81% 19%	 59% 41%	 82% 18%	 73% 27%	 71% 29%	 85% 15%	 100% 0%	 79% 21%

*Note: percentages may not equal 100% due to rounding.

In terms of intra-jurisdictional migration within Canada, according to the Canadian Institute for Health Information (CIHI), of the 62,307 physicians in Canada in 2007, 550 (0.8%) moved to another jurisdiction within the country in that year.[25] This is the lowest rate in five years; the average for 2002-2006 was higher at 1.0-1.3%.[26] From 2003 to 2007, only Alberta and British Columbia experienced a continuous net gain of physicians due to intra-jurisdictional migration, while Newfoundland and Labrador, Quebec, Manitoba, Saskatchewan, and the Yukon all lost physicians in each of those years.[27] (Table 2)

Table 2: Net Migration Between Jurisdictions, Canada, 2003-2007[28]						
Prov./Terr.	2003	2004	2005	2006	2007	Total Net (-/+)
NL	-30	-28	-24	-13	-33	-128
PEI	+2	+7	-1	-3	+1	+6
NS	-4	+3	-8	-29	0	-38
NB	+3	-4	-9	-6	+10	-6
QC*	--	-11	-10	-30	-27	-78
ON	+61	+25	-14	-49	+15	+38
MB	-34	-22	-22	-14	-21	-113
SK	-45	-38	-37	-50	-14	-184
AB	+13	+34	+10	+90	+45	+192
BC	+84	+29	+117	+112	+26	+368
YK	-2	-1	-4	-4	-2	-13
NWT	-2	8	-4	-3	0	-1
NU	-1	-2	6	-1	0	+2

Note: According to CIHI, Quebec data in 2003 do not reflect the annual update from the CMQ. Due to this discrepancy, 2003 data are not presented in the Quebec profile from the original CIHI source data.

Dubbed the "circle game" by Dauphinee[29], this longstanding phenomenon of continuous net losses by the smaller jurisdictions within Canada provides net gains in physicians to three of Canada's

24 CIHI. (2008). op.cit. This table is adapted from "Table 20.0: Number and Proportion of Physicians Receiving Their MD Graduation from Canadian and Foreign Universities, by Specialty, Canada, 2006." 117.
25 Ibid. See "Table 13.0: Physicians Who Moved Between Canadian Jurisdictions by Place of MD Graduation, Years Since MD Graduation, Province/Territory, 2007." 104.
26 See CIHI. (Revised November 2007). *Supply, Distribution and Migration of Canadian Physicians*, 2006, 4-5. Retrieved from http://secure.cihi.ca/cihiweb/products/SupDistandMigCanPhysic_2006_e.pdf.
27 CIHI. (2008). op.cit., 5.
28 CIHI. (2008). op.cit., 47-59.

most populous and wealthy provinces: British Columbia, Alberta and, with the exception of 2005 and 2006, Ontario. Consequently, this in turn creates pressure within those jurisdictions losing physicians to recruit more IMGs (see Appendix 3). Using earlier CIHI data, Dauphinee has observed that

> in absolute terms, the total number of physicians lost due to interprovincial migration in 2004 for Newfoundland, Manitoba, and Saskatchewan combined was almost five times the number who returned. As in the previous few years, these three provinces were the biggest losers proportionally . . . . Interestingly, the three provinces with net losses of physicians—Newfoundland and Labrador, Manitoba, and Saskatchewan—also recruit from outside Canada most frequently, on a proportional basis, presumably to offset the internal losses of their own graduates within Canada.[30]

Of those physicians who migrate within Canada, it is noteworthy that while IMGs comprise 22 per cent of the country's physician population, they accounted for 32.62 per cent (184 of 564) of the physicians who migrated intra-jurisdictionally in 2007. (Table 3)

Table 3: Canadian-trained and international medical graduates who moved between jurisdictions, Canada 2007[31]

P/T	NL	PEI	NS	NB	QC	ON	MB	SK	AB	BC	YT	NWT	NU	CAN
IMGs	33	1	17	7	8	26	12	33	22	23	2	0	0	184
CN grads	3	2	27	12	47	106	16	18	54	51	1	1	2	340
All MDs	45	5	48	20	56	134	38	53	80	78	3	2	2	564

As Table 3 shows, Newfoundland and Labrador, Manitoba, Saskatchewan and the Yukon, which rely more heavily on IMGs, also experienced greater migration of these providers on a percentage basis in comparison to other jurisdictions. Smaller jurisdictions with a ratio of IMGs to Canadian-trained physicians more in line with the pan-Canadian average or lower—such as Prince Edward Island, Nova Scotia and New Brunswick—also experienced a greater migration of IMGs on a percentage basis than other larger jurisdictions such as Ontario, Alberta and British Columbia. In fact, according to a recent study examining recruitment and retention of new physicians in Newfoundland and Labrador, in 2004, of the IMGs who moved out of Newfoundland and Labrador, to elsewhere in Canada,

> 25.6% were working in Western Canada (British Columbia, Alberta or Saskatchewan), 62.7% in Ontario, and 11.6% in the Maritimes (Prince Edward Island or Nova Scotia). The majority of these IMG physicians (76.7%) were working in urban communities (10,000 or

29 W. Dale Dauphinee. (December 2006). "The Circle Game: Understanding Physician Migration Patterns Within Canada." *Academic Medicine* 81(12), S49-S54. Retrieved from http://www.academicmedicine.org/pt/re/acmed/pdfhandler.00001888-200612001-00010.pdf;jsessionid=JkhGfnWT2vvPNyfHVrrlfrPBm0nN4bDvcxGgDQz6DkwCY19lgVxc!-1594442060!181195628!8091!-1.
30 Ibid, S51.
31 CIHI (2008). Adapted from "Table 13.0 Physicians Who Moved Between Canadian Jurisdictions, by Place of Graduation, Years Since Graduation and by Province/Territory, Canada, 2007." 104.

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more population). These findings confirm the widely held belief that NL provides an entry point to practice elsewhere in Canada. They also suggest that most IMG physicians move to urban centres where a larger number of people who share their ethnic background live.[32]

While IMGs have a higher rate of intra-jurisdictional migration than Canadian-trained physicians, it is important to note as well the migration of Canadian-trained physicians from smaller provinces. In fact, according to the same study noted above concerning Newfoundland and Labrador physicians, for Canadian-trained and IMGs,

> retention in a cohort of newly licensed FPs/GPs [family practitioners / general practitioners] was low; fewer than 1 in 7 physicians remained in the province up to 7 years later. Half had left after roughly 2 years, although locally trained physicians remained in the province twice as long as IMGs and CMGs [Canadian medical graduates]. There was no difference between the retention of IMGs and that of CMGs. IMGs remained in the province for roughly 1 year after earning a full licence.[33]

So what are the implications for the education, training, licensure and registration of physicians given these longstanding patterns of physician migration as regulatory changes unfold in Canada?

III. How May Regulatory Changes Affect the Assurance of Uniform Quality of Care?

The majority of physicians practicing in Canada undergo a similar education and evaluation process to ensure attainment of defined core competencies. These measures exist in Canada to ensure that physicians receive rigorous and systematic assessment to meet the highest possible standards so that Canadians receive high quality, safe health care from these providers.

In addition, physician training in Canada is based on the CanMEDS competency framework, which was adopted by the Royal College in 1996 and has now become an accepted standard throughout Canada and in many other countries around the world. The CanMEDS framework defines the core competencies associated with seven roles assumed by physicians during their practice: Medical Expert, Communicator, Collaboration, Advocate, Scholar, Professional and Manager.[34,35] Similarly, the College of Family Physicians of Canada has recently developed CanMEDS-Family Medicine.

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32 Maria Mathews, Alison C. Edwards, and James T.B. Rourke. (2008). "Retention of provisionally licensed international medical graduates: a historical cohort study of general and family physicians in Newfoundland and Labrador." *Open Medicine*: 2(2): 37-44. Retrieved from http://www.openmedicine.ca/article/viewArticle/123.
33 Ibid. This study did not examine data concerning specialists for Newfoundland and Labrador.
34 Royal College of Physicians and Surgeons. *The CanMEDs Project Overview, 2005*. Retrieved from http://Royal College.medical.org/canmeds/CanMeds-summary_e.pdf.
35 Jason R. Frank (ed.). (2005). Office of Education, Royal College of Physicians and Surgeons. *The CanMEDS 2005 Physician Competency Framework: Better standards. Better physicians. Better care.* Retrieved from http://Royal College.medical.org/canmeds/CanMEDS2005/CanMEDS2005_e.pdf.

As changes to the regulatory landscape in Canada unfold, it is vital to ensure that these developments do not have unintended consequences on measures intended to assure safe, high-quality care such as standards for education, training, licensure and registration, which may result in the erosion of the standard of care.

In February 2001, the medical licensing authorities of Canada signed a Draft Mutual Recognition Agreement to enable compliance with the AIT by the medical profession. This agreement accepts the following requirements for intra-jurisdictional mobility:

- the Licentiate of the Medical Council of Canada (LMCC);
- evidence of satisfactory postgraduate training as demonstrated by certification from the Royal College or College of Family Physicians of Canada (CFPC);
- a medical degree or equivalent qualification acceptable to the licensing authority;
- language proficiency;
- Canadian citizenship or permanent residency;
- proof of good standing in current or prior medical jurisdictions; and
- a current active practice.[36]

The above criteria constitute what is known as "full registration" in Canadian jurisdictions. Exceptions to the above criteria are permitted in each jurisdiction, including the allowance of each licensing authority to "retain or develop temporary, conditional, restricted or other forms of licensure to deal with specific circumstances in its jurisdiction."[37]

In December 2007, medicine was deemed to be not in compliance with the provisions concerning labour mobility under the AIT by the FPT Labour Mobility Coordinating Group. As a result, members of the Federation of Medical Regulatory Authorities of Canada (FMRAC) met in February 2008 with federal government officials to consider changes to the 2001 agreement.[38]

While the education and examination process for most physicians is similar, there is more variation across Canada concerning their licensure and registration. Each province and territory has responsibility for the regulation of the practice of medicine in their respective jurisdictions. Generally, if physicians have fulfilled all the requirements of family practice or specialty certification procedures described above they receive a full license. If they are in the process of fulfilling these requirements because they are still in training, or, much more commonly, because they are IMGs and require assessment of their qualifications and perhaps additional training, they receive what is

36 Medical Licensing Authorities of Canada. Draft Mutual Recognition Agreement. (February 2, 2001).
37 Ibid, 2.
38 Connie Côté. (November 24, 2008). "Agreement on Internal Trade – Update on Mutual Recognition Agreement for Physicians." Federation of Medical Regulatory Authorities of Canada. Presentation to Royal College Education Committee, slide 7.

usually known as a provisional (also sometimes called, as noted above, conditional, restricted, limited, temporary or educational) license[39, 40,41] (see Appendix 4).

Provisionally licensed physicians such as IMGs can practice medicine without passing some or all of the required Medical Council of Canada (MCC) exams and subsequent Canadian postgraduate medical training. These providers are employed frequently to address physician shortages and meet immediate health care needs in rural and remote areas of Canada. "In 2004, IMGs accounted for 26.3% of all physicians in rural Canada, compared with 21.9% in urban areas. Also, IMGs accounted for 26.9% of family physicians in rural areas, compared with 22.6% in urban areas. In other words, there is a heavier reliance on foreign-trained physicians in rural Canada."[42,43]

Rural and remote areas throughout Canada are particularly affected by physician maldistribution. "Between 1991 and 1996, the proportion of physicians working in Canada's small towns and rural areas declined from 14.9% to 9.8% while the population in those areas increased from 19.2% to 22.2% of the total population; physicians and hospitals are increasingly concentrated in urban and urban fringe areas."[44]

Traditionally it has been difficult to attract Canadian-trained physicians to these areas.[45] Provisionally licensed IMGs employed in underserviced areas usually must agree to work for a specific period before qualifying for a full license. Following the acquisition of their full license, IMGs may locate anywhere in Canada. Similar to the tendencies of their Canadian-trained counterparts, many IMGs gravitate to urban centres upon achieving a full license.[46,47] In addition

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39 Rick Audas, Amanda Ross and David Vardy. (November 22, 2005). "The use of provisionally licensed international medical graduates in Canada." *Canadian Medical Association Journal*: 173 (11): 1315-1316. Retrieved from http://www.cmaj.ca/cgi/reprint/173/11/1315. This is based on an earlier paper by the same authors titled "The Role of International Medical Graduates in the Provision of Physician Services in Atlantic Canada." (December 2004.) Retrieved from http://www.mun.ca/harriscentre/Reports/IMG-Atlantic_Metropolis-FINAL.pdf.
40 See also Morris L. Barer and Greg L. Stoddart. (June 1999). "Improving Access to Needed Medical Services in Rural and Remote Canadian Communities: Recruitment and Retention Revisited." Centre for Health Services and Policy Research, University of British Columbia, 15. Retrieved from http://www.srpc.ca/librarydocs/BarSto99.pdf.
41 For specific terminology concerning licensure in each jurisdiction, see Mary Colbran-Smith. (February 2006). "Provincial/Territorial Registration and Licensure Terminology for Canadian Physicians: Focus on International Medical Graduates (IMGs)." Prepared for the Federation of Medical Regulatory Authorities of Canada.
42 CIHI. (2005). "Geographic Distribution of Physicians in Canada: Beyond How Many and Where." x. Retrieved from http://secure.cihi.ca/cihiweb/products/Geographic_Distribution_of_Physicians_FINAL_e.pdf.
43 Historically, the percentage of IMGs practicing in rural and remote areas has not differed substantially from that of Canadian-trained physicians. As Barer and Stoddart have pointed out, "in 1998, only about 26% of those practicing outside census metropolitan areas were FMGs [foreign medical graduates, or IMGs]. This was not appreciably different than the overall ratio of FMGs to all practicing physicians in Canada." (See Barer and Stoddart, op. cit., 16.) However, while the percentage of IMGs within the overall supply of physicians has declined significantly more recently, the percentage of IMGs practicing in rural and remote areas has not, hence the more recent disparity between the two.
44 Canadian Labour and Business Centre for Task Force Two. (January 2003). *A Physician Human Resource Strategy for Canada. Physician Workforce in Canada: Literature Review and Gap Analysis. Final Report*, p. 39. Retrieved from http://www.physicianhr.ca/reports/literatureReviewGapAnalysis-e.pdf.
45 Audas et al., 2004 and 2005, op.cit.
46 See Barer and Stoddart, op. cit., 16.
47 In fact, "the largest number of IMGs are located in and near Toronto, Canada's largest and most multicultural city." Dauphinee, 2006, op.cit.

to chronic concerns regarding the accessibility of care in rural and remote areas,[48] this high turnover of both Canadian- and foreign-trained physicians in these areas[49] has raised concern regarding continuity of care in such regions given the correlation between patient satisfaction and a relationship with a long-term physician.[50]

This is particularly noteworthy given that "some (poorer) provinces that rely heavily on provisionally licensed IMGs may be serving as an initial screening mechanism for other (wealthier) provinces that wish to recruit fully licensed IMGs, allowing them to avoid granting provisional licenses."[51] If this is true, then it would be contrary to the intent behind the guidelines for meeting the obligation for labour mobility under the AIT, which state that "temporary licensing should not be used as a replacement for recognizing the qualifications of out-of-province workers on a permanent basis."[52]

Given their continuous loss of physicians, smaller jurisdictions within Canada are effectively penalized in terms of recruitment costs since

> 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.[53]

These jurisdictions are also negatively impacted in terms of costs associated with training since

> (i) the correlation between provincial net migration and graduation rates is negative (-0.41) and significant, [and] (ii) the correlation between net migration and the share of IMGs is also negative and significant (-0.39). In other words, it seems that provinces that train less benefit more from interprovincial migration and those that lose more through interprovincial migration recruit more internationally. As a result, more than 80% of the practicing doctors in Quebec have been trained in the province compared to around 58.5% for Ontario and 40% for Alberta, Newfoundland and Labrador and Nova Scotia. This percentage is close to 25% for British Columbia.[54]

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48 "Canadians living in rural and remote areas of the country have always found physician services less accessible than their city-dwelling counterparts. The problem is as old as written commentary on physician resource issues in this country." Barer and Stoddart, op. cit., 2.

49 For example, while most IMGs do not stay in Newfoundland after achieving full licensure, with the exception of Canadian medical graduates trained in the province at Memorial University, the retention of Canadian-trained medical graduates is no better than IMGs; see Mathews et. al., op.cit.

50 Audas et. al., 2004, op. cit., 21, and 2005, op. cit., 1316.

51 Audas et. al., 2005, op.cit., 1316.

52 Forum of Labour Market Ministers Coordinating Group. (February 2003). *Agreement on Internal Trade. Guidelines for meeting the obligations of the Labour Mobility Chapter*, Revised Edition, 26. Retrieved from http://www.hrsdc.gc.ca/en/ws/publications/lm/guidelines_E.pdf.

53 Audas et. al., op. cit., 21.

54 Jean-Christophe Dumont, Pascal Zurn, Jody Church and Christine Le Thi. World Health Organization. (2008). *International Mobility of Health Professionals and Health Workforce Management in Canada: Myths and Realities. OECD Health Working Papers* #40, 32. Retrieved from http://www.oecd.org/dataoecd/7/59/41590427.pdf.

The "circle game" of physician migration also impacts forms of medical registration across jurisdictions. For example, "Saskatchewan and Newfoundland and Labrador . . . tend to have more flexible policies for medical registration in order to attract foreign-trained doctors."[55] Recruitment and retention challenges are particularly acute in Atlantic Canada due to a combination of depressed economic circumstances, a difficult climate, limited opportunities for physicians to interact socially and culturally with their peers, especially for physicians from multicultural backgrounds, and the lowest remuneration in Canada.[56] As a result, there "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."[57]

While mutual recognition of registration has long been sought by many in the medical community in Canada as a way to address the maldistribution of physicians and allow providers to practice where they wish, concern has arisen that the amendments to the AIT may in fact exacerbate physician shortages in certain jurisdictions in Canada. Commenting on the July 2008 announced amendments to the AIT, the Royal College noted that "without appropriate safeguards, the movement of physicians away from certain provinces and territories and towards the 'magnet' provinces might accelerate, increasing the health imbalance between provinces."[58] The College of Physicians and Surgeons of Alberta (CPSA) has also expressed its concern:

> It appears that the idea of free labor mobility is based on a free market, capitalistic philosophy, the idea being that labor will move where there is work and income . . . . It is naïve to think that all provinces will gain by this direction; rather, there will be winners and losers, and the losers will almost certainly include under-serviced communities.[59]

While there appears to be more willingness within the regulatory framework of Atlantic provinces to absorb physicians such as IMGs, whose education, training and work experience differ from the majority of physicians within Canada, as one way to address recruitment and retention challenges, these challenges also affect underserviced areas within Canada's larger and wealthier jurisdictions as well, with concomitant influences on licensing within these jurisdictions to meet societal health needs in these areas (see Appendix 4). For example, physicians in Alberta, currently Canada's wealthiest province, who are licensed under Part 5 of the Special Register, are not required to have the LMCC or attain it.[60] In British Columbia, physicians with temporary registration work in underserviced areas and are expected to complete the requirements for full licensure by passing the MCC Evaluating Exam in one year and the LMCC within three years. In Ontario, several different measures are in place to reduce barriers for physicians to licensure, including the recently

55 Ibid, 31.
56 Audas, et. al. op. cit., 20.
57 Ibid, 20-21.
58 Royal College of Physicians and Surgeons. (August 2008). "Message from the CEO. Breaking Down the Barriers: Interprovincial Movement of Physicians and Surgeons." Retrieved from http://Royal College.medical.org/about/CEO/Message_from_CEO_aug08_e.pdf.
59 See "Registrar's Report: AHSA and labor mobility: challenges ahead," op. cit.
60 Personal communication with Dr. Trevor Theman, Registrar, CPSA, October 14, 2008.

introduced alternative pathways to registration, which add additional pathways to licensure for those practitioners who are not certified by either the Royal College or the CFPC.

As such, in both the larger and wealthier, and the smaller and less-resourced jurisdictions across Canada, some provisionally licensed physicians must achieve Canadian credentials within a specified period of time in addition to other restrictions, such as serving in an underserviced area as a condition of their practice. However, not all such provisionally licensed physicians are required to achieve these benchmarks, or have more time to attain them. This enables some physicians to practice who would not otherwise qualify for licensure and provides access to medical services for underserved communities. However, if "mutual recognition means no additional requirements imposed on the worker and no need for individual case-by-case assessment"[61] and each jurisdiction" must demonstrate why an additional requirement is necessary to achieve a legitimate objective and that it is not, for example, a disguised barrier to mobility,"[62] given the variation in education and credentials underlying provisional licenses across Canada, this begs the question as to whether regulators will truly have the option of requiring physicians who want to move to their respective jurisdictions to prove their competency. FMRAC has indicated its objections to portability of anything less than full licensure,[63] and is concerned that the application of the AIT amendments to physicians with provisional licenses will result in the "erosion of the standards for qualifications [and] exodus of physicians from underserviced areas."[64] Accordingly, it is advocating that either health be exempted from the AIT provisions or, failing this, that mobility provisions under the agreement apply only to those physicians who hold full licensure.[65] CPSA has stated that "we are not willing to reduce the criteria we consider to be the minimum that would allow safe independent practice."[66]

While provisionally licensed physicians are essential to meeting the needs of Canadians, particularly in rural and remote areas, provincial and territorial regulators restrict the activities of these physicians to ensure the provision of safe, quality care. The proposed wording for the amended chapter seven governing labour mobility approved by Ministers of Internal Trade on December 5, 2008, (but still subject to Cabinet approval at the time of publication of this paper) states that provincial and territorial regulators will not be limited in their ability to "assess the equivalency of a practice limitation, restriction or condition imposed on a worker in his or her current certifying jurisdiction"[67] However, regulatory authorities must ensure that "any such measure is the same as, or substantially similar to but no more onerous than, that imposed by the regulatory authority on its own workers . . . and the measure does not create a disguised restriction

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61 See Vepstas, op. cit., emphasis in the original, slide 12. The proposed AIT amendments will apply to internationally-trained workers and "grandparented workers who are licensed in one jurisdiction." [slide 8] A "qualified" worker is defined as "licensed, certified or registered by a regulatory authority," but there is no distinction between classifications of licensure or registration. [slide 3]
62 Ibid., slide 13.
63 Personal communication with FMRAC Executive Director Fleur-Ange Lefebvre, October 16, 2008.
64 Côté, op. cit., slide 15.
65 Ibid., slide 16.
66 See "Registrar's Report: AHSA and labor mobility: challenges ahead," op.cit.
67 Draft Protocol of Amendment, Agreement on Internal Trade, Chapter 7 (December 2008), article 706, clause 4 (d). Provided on request by AIT Internal Trade Secretariat Executive Director Anna Maria Magnifico, January 23, 2009. (The Protocol was not publicly released on December 5, 2008, but only made available in January 2009 on request.)

on labour mobility."[68] This presupposes harmonization of regulatory approaches to physician licensure and registration across jurisdictions within Canada (as advocated by Task Force Two), but there is a lack of clarity concerning what terms such as "onerous" and "disguised restriction to labour mobility" actually mean, which require further discussion.

In addition, given the range of differences underlying provisional medical licenses across jurisdictions within Canada that place restrictions on physician practice, harmonization will impose significant requirements on all regulatory authorities to ensure congruency between jurisdictions. This is particularly important given that regardless of the differences underlying provisional medical licenses, the draft protocol of amendment clearly states that

> a mere difference between the certification requirements of a Party related to academic credentials, education, training, experience, examination or assessment methods and those of any other Party is not, by itself, sufficient to justify the imposition of additional education, training experience, examination or assessment requirements as necessary to achieve a legitimate objective. In the case of a difference related to academic credentials, education, training or experience, the party seeking to impose an additional requirement must be able to demonstrate that any such difference results in an actual material deficiency in skill, area of knowledge or ability[69]

Such an assessment process will require the appropriate infrastructure concerning medical licensure and registration between jurisdictions that does not as of yet exist in Canada; without it, pan-Canadian approaches to medical licensure and registration as advocated by Task Force Two cannot succeed. If the amended AIT is implemented without this infrastructure already in place, this may instead undermine efforts toward harmonization of medical licensure and registration as a standard of safe, high-quality care as provisionally licensed physicians move between jurisdictions before achieving full registration and the criteria governing full registration is potentially eroded as the standard to achieve. Moreover, many questions surround the issue of how jurisdictions will assess provisional medical licenses which merit further discussion.[70]

The draft protocol of amendment for Chapter Seven states that regulators can "refuse to certify a worker or impose terms, conditions or restrictions on his or her ability to practice . . . to protect the public interest as a result of complaints or disciplinary or criminal proceedings . . . relating to the competency, conduct or character of that worker,"[71] However, the same provisions under the protocol of amendment that such measures are "onerous" and do not "create a disguised restriction on labour mobility"[72] are present. Again, without further clarity concerning this term, the ability of

68 Ibid, article 706, clause 4 (e).
69 Ibid, article 708, clause 2.
70 For example, if provisionally licensed physicians are able to move without achieving licensure in their "home" jurisdictions, how exactly will their jurisdiction of destination decide if they should receive a full license? What will be the measures of quality? How will standards and benchmarks across jurisdictions be compared if provisionally licensed physicians can move between jurisdictions without achieving full licensure before migrating? If a provisionally licensed physician surpasses some benchmarks but not others, how will she or he be assessed?
71 Draft Protocol of Amendment, Agreement on Internal Trade, Chapter 7, article 706, clause 4 (a).
72 Ibid, article 706, clause 4 (f).

regulators to ensure the provision of safe, high-quality care within their respective jurisdictions may be placed in doubt.

Current negotiations underway concerning the details of Québec-France subagreement on mutual recognition include a provision that mutual recognition will only apply to those MDs who have been trained in either France or Quebec. Neither physicians who have trained in Canada who seek to use the AIT to transfer to France through Quebec nor physicians who have trained in other parts of the European Union who seek to use the new agreement to transfer to Quebec through France will supposedly be able to do so.[73] Licensing authorities in each jurisdiction are supposed to have the right to evaluate and reject any individual applicant under this arrangement. However, given that the ability of regulators to impose additional requirements will effectively be curtailed under the AIT amendments, it is difficult to see how regulators could halt the mobility of French-trained physicians once they arrive here. As well, it is reasonable to conclude that other provincial and territorial jurisdictions will, in effect, be bound to accept the standards agreed to under such international agreements since physicians licensed under these arrangements will subsequently have unfettered mobility according to the AIT's provisions.

Recent provincial regulatory evolutions in registration may also be impacted by the AIT given longstanding patterns of physician migration within Canada. For example, the CPSO alternative pathways to registration seek to address physician shortages in this province. While the objective of reducing barriers to licensure of physicians is commendable, serious concerns have been expressed that the proposed new pathways 5 and 6 may have unintended consequences, resulting in the erosion of care in Ontario. These concerns, which have been shared with the CPSO's registrar, are based on a number of considerations, including the following:

- Standards of mentorship, supervision and assessment are not clearly defined under the proposed new pathways. Such standards are particularly important given that practice in many disciplines in the United States and other jurisdictions often differs significantly from the norm accepted in Canadian provinces and territories. This raises the need to ensure that an appropriate assessment of physicians in practice exists and that variances in the educational standards for other countries are not resulting in substantial differences in scope of competence compared to that of physicians trained and certified in Canada. To do otherwise may result in unplanned variations in quality of care provided in different parts of Ontario and, potentially, in other areas of Canada as physicians licensed under these new Ontario pathways gain access to licensure in other Canadian jurisdictions with the implementation of amendments to the AIT.
- Reliance on an already over-taxed medical workforce to support these pathways for assessments, supervision, mentorship and teaching may result in unintended consequences, such as a negative impact on the training of residents in Canadian postgraduate medical education programs. Chief among these is the concern that the increased resource requirements to support the new pathways could negatively impact the training of residents enrolled in the province's postgraduate medical education programs, thereby hampering their attainment of competency.

73 See note 14.

- Use of the 29 jurisdictions previously assessed by the Royal College as the basis for acceptance of training may be problematic at this juncture due to the need to review, revise and possibly extend jurisdictional assessment.
- These changes to registration may have the potential of exacerbating longstanding physician migration patterns away from smaller provinces to urban centres in Ontario given that certification is not required. In fact, given that the proposed AIT amendments are supposed to apply to physicians with both full and provisional licensure, then physician migration away from smaller, less wealthy jurisdictions could increase considerably.

While Royal College certification should not be a rigid process inimical to change and improvement over time in keeping with evolutions in medical education and training to meet societal health needs, the Royal College is committed to ensuring that standards are maintained to ensure the provision of quality, safe care to patients.

IV. Conclusion

Governments, health planners, health providers and policy-makers have long struggled with issues involving physician human resources. In recent years, provinces and territories have been actively developing various approaches to address HHR shortages in their respective jurisdictions. There have also been pan-Canadian initiatives carried out by the health professions, including Task Force Two. Central to this body's call for a harmonized pan-Canadian process that ensures that the licensure of physicians in every Canadian jurisdiction follows standardized practices is "the creation of a body or mechanism to support and facilitate coordinating mechanisms in developing and establishing future pan-Canadian HHR plans to ensure Canada has the right number of physicians, working in the right places and in an optimal way to meet the needs of Canadians."[74]

As these changes to the physician regulatory landscape across Canada unfold, such a mechanism is urgently needed to ensure that developments do not aggravate physician maldistribution or balkanize standards needed to ensure the provision of high quality, safe care to all Canadians regardless of where they live. A pan-Canadian approach would ensure that a sufficient physician supply and skill mix exist in all Canadian jurisdictions to meet societal health needs. Otherwise, longstanding patterns of physician migration may intensify, worsening access to physician services and placing the standard of care some Canadians receive into question. Indeed, as was noted in a 2000 study concerning the province of British Columbia,

> the report highlights the degree to which planning for physicians in B.C. is constrained by the unrestricted migration patterns of physicians from other provinces. As such, training and licensing policies in effect in other provinces have implications for B.C.'s physician supply. Thus, physician training policies in B.C. and elsewhere in Canada should be

74 Task Force Two, op. cit., 8.

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considered in the national context to allow rational health workforce (and health services) planning at the Health Region level.[75]

In the interim, the following questions merit discussion:

1. What are the implications for appropriate physician supply across Canada, (geographic distributions and skill mix/type) given that the AIT amendments will extend mutual recognition to those physicians working under provisional licenses? If some provinces already serve as a screening mechanism for other provinces to recruit fully licensed IMGs, will the AIT amendments, possibly coupled with international agreements, exacerbate this trend?
2. Given the AIT amendments, especially as they may pertain to provisional licenses, and the difficulties involved in assessing training programs in international jurisdictions, how can regulators ensure high-quality, safe patient care?
3. With the growing tendency on the part of regulatory authorities to move away from Canadian certification as standards for licensure of medical specialists, what measures, if any, would be appropriate for certifying bodies and other organizations concerned with standards to undertake in order to ensure the provision of safe, quality care by appropriately trained physicians and surgeons?

The Royal College has provided commentary concerning the potential benefits and pitfalls of the amendments to the AIT to FPT Ministers of Health and Labour in a letter sent on December 5, 2008 (see Appendix 5).

With the release in January 2009 of the specific proposed text for the amended Chapter Seven governing labour mobility under the AIT, the lack of clarity in the wording reaffirms the need for further discussions. In addition, the presupposition of this agreement that the infrastructure to support harmonization of medical licensure and registration (or indeed other professions) already exists between jurisdictions within Canada is ill founded. Given the considerable variation and complexity in medical registration between provinces and territories, regulatory authorities may not be able to perform their duty, in order to protect the public, to assess the competency of physicians who wish to move to their respective jurisdictions. The health of Canadians may be in doubt without

1. the necessary time and resources to develop the infrastructure needed to support the harmonization of medical licensure and registration on a pan-Canadian basis prior to the coming-into-force of these changes;
2. any information concerning how provisional licenses are to be assessed in terms of mutual recognition across jurisdictions; and
3. greater clarity regarding what constitutes a “disguised restriction to labour mobility.”

75 A. Kazanjian, R.J. Reid, N. Pagliccia, L. Apland, L. Wood. (June 2000). Health Human Resources Unit Centre for Health Services and Policy Research, University of British Columbia. *Issues in Physician Resources Planning in B.C.: Key Determinants of Supply and Distribution, 1991-96*. A Report to the Post-Graduate Medical Education Advisory Committee, 123. Retrieved from http://www.chspr.ubc.ca/files/publications/2000/hhru00-02_pgme.pdf.

The Royal College will continue to work with partner health organizations and other stakeholders to make its concerns known to FPT governments regarding the potential and unanticipated ill effects of these proposed changes during the implementation period. The College will also help develop measures that will ensure the maintenance of high-quality care for Canadians, including advocating for rigorous evaluation of the results emanating from these changes to the AIT on the provision of timely and safe care in Canada. In addition, the Royal College will also examine its own certification protocols to ensure that the processes by which physicians achieve certification as specialists in Canada keep pace with medical education and training to meet societal health needs.

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Appendix 1[76]

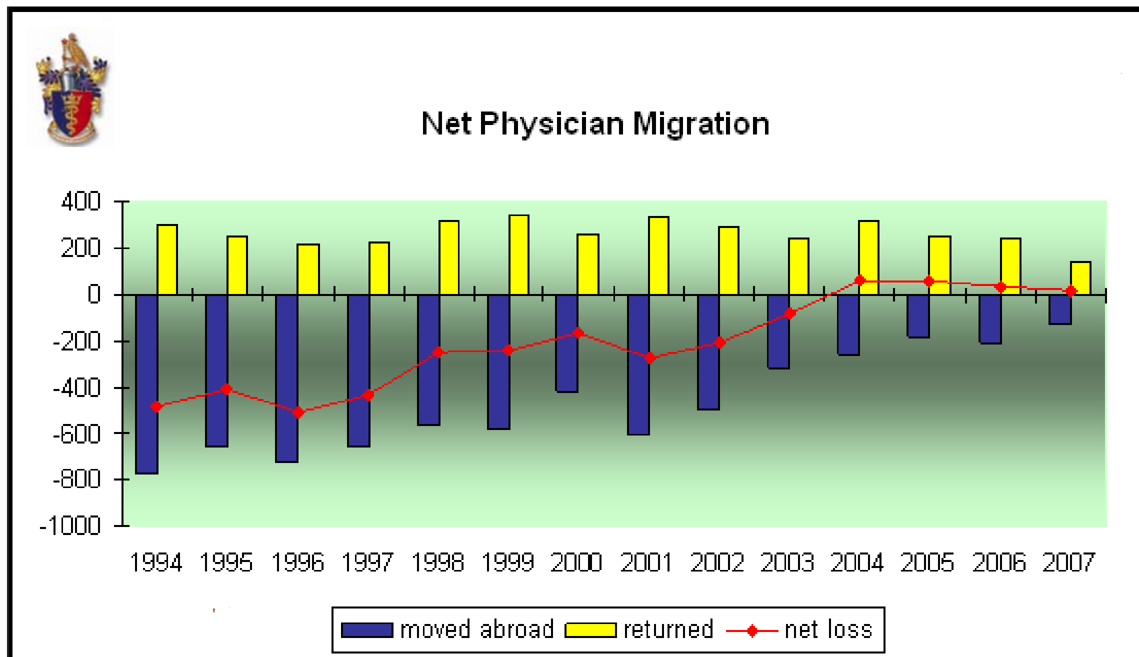
Table 4: A snapshot of physician mobility by jurisdiction within Canada, 2003-2007

P/T	+/- # of MDs	+/- pop.	Influences / overall picture
NL	+7.5%	-2.0%	• 11.4% increase in # of Canadian-trained MDs • 20% decrease in # of IMGs • # of MDs (2) returning from abroad remained unchanged • Increase in # of MDs moving abroad • Net losses each year due to intra-jurisdictional migration within Canada
PEI	+11.8%	+1.0%	• 10.1% increase in # Canadian-trained MDs • 6.7% decrease in IMGs • Loss of MDs in 2005 (1) and 2006 (3) and gain in 2007 (1) through intra-jurisdictional migration
NS	+9.1%	-0.2%	• 4.6% increase in # Canadian-trained MDs • 12.3% increase in # of IMGs • # of MDs returning greater than # moving abroad • Significant loss of MDs due to intra-jurisdictional migration in 2006 (29), but equal # leaving as moving to NS in 2007
NB	+13.4%	-0.02%	• 12.2% increase in # of Canadian-trained MDs • 10.3% increase in # of IMGs • Increase in # of physicians moving abroad and slight increase in # of MDs returning from abroad • Net losses from intra-jurisdictional migration in 2004, 2005 and 2006; net gain in 2007
QC*	--	--	• In 2007, QC experienced a net loss of 27 MDs through intra-jurisdictional migration • More MDs moving abroad than returning in 2007, but rate of moving abroad the lowest in five years
ON	+3.9%	+4.3%	• 3.6% increase in # of Canadian-trained MDs • 3.7% increase in # of IMGs • Declines in both # of MDs moving abroad and also MDs returning from abroad • Net gains in 2007 from intra-jurisdictional migration for the first time since 2004
MB	+2.6%	+2.4%	• 4.0% increase in # of Canadian-trained MDs • 3.7% decrease in # of IMGs • Net losses each year due to intra-jurisdictional migration within Canada
SK	+7.7%	+1.2%	• Decline in # of MDs moving abroad • Increase in # of MDs returning from abroad • Net losses each year due to intra-jurisdictional migration within Canada
AB	+18.8%	+9.9%	• 14.5% increase in # of Canadian-trained MDs • 21% increase in # of IMGs • 40% decline in # of MDs emigrating abroad • 26.5% decline in # of MDs returning from abroad • Since 2004, more MDs returned from abroad than moved abroad • Net gains each year from intra-jurisdictional migration
BC	+4.6%	+5.6%	• 5.1% increase in # of Canadian-trained MDs • 4.6% increase in # of IMGs • 42.2% decline in # of MDs moving abroad • More MDs returned from abroad than moved abroad in 2007 (30 compared to 26) • Net gains each year from intra-jurisdictional migration
YK	+30.9%	+1.3%	• Net losses each year from intra-jurisdictional migration
NT	+14%	-0.3%	• 2.9% decrease in #of Canadian-trained physicians • 75% increase in # of IMGs • Net intra-jurisdictional migration zero in 2007
NU	-10%	+6.2%	• Increase in # of Canadian-trained MDs • Decrease in # of IMGs • Net intra-jurisdictional migration zero in 2007

*Note: According to CIHI, Quebec data in 2003 do not reflect the annual update from the CMQ. Due to this discrepancy, 2003 data are not presented in the Quebec profile nor are comparison from 2003-2007 in the original CIHI source data.

76 All data are from CIHI, 2008, op. cit., 5-14.

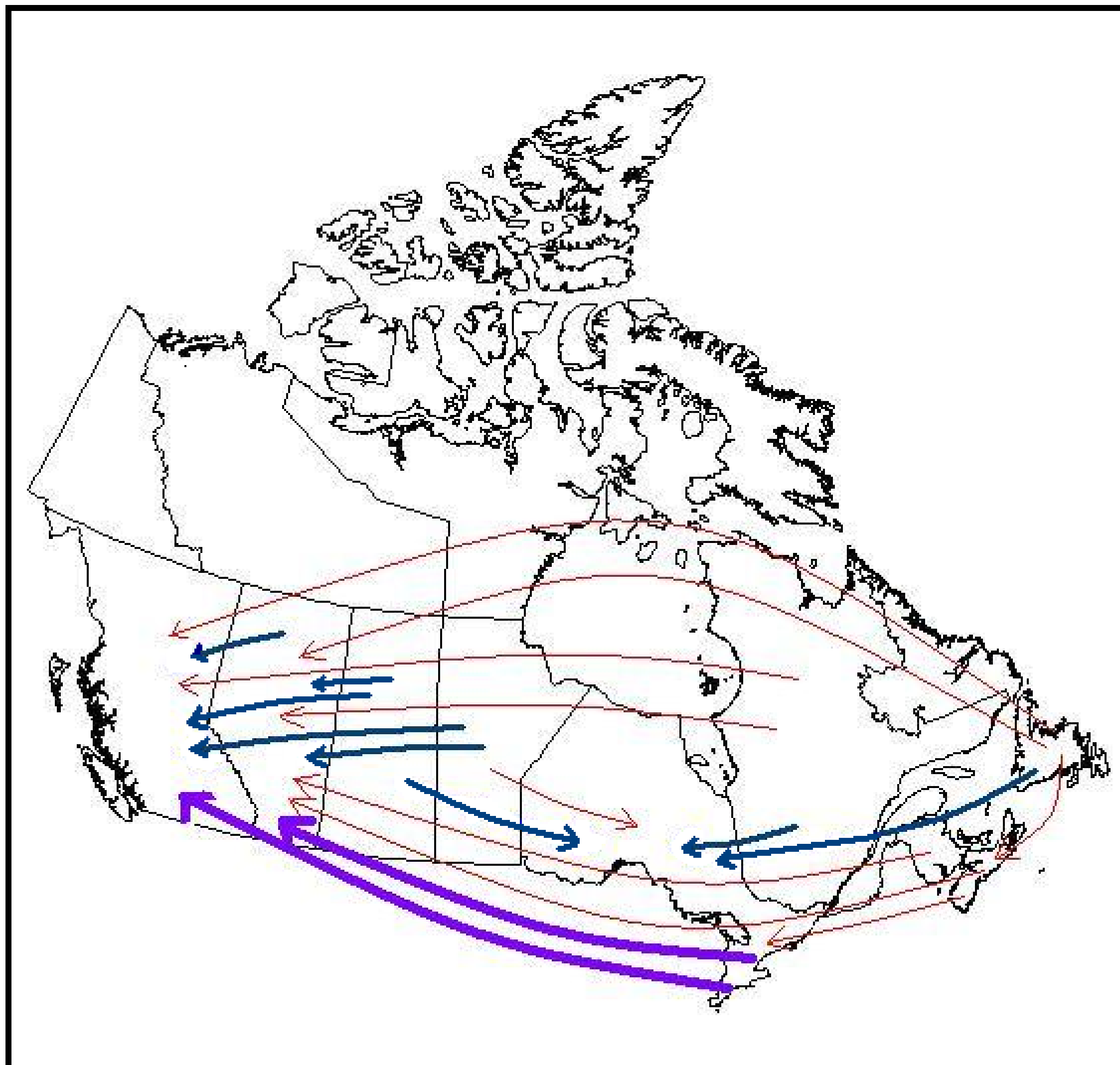
Appendix 2[77]

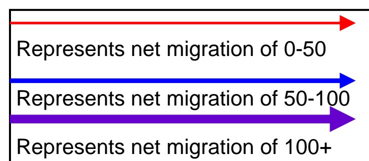


77 Adapted from "Physicians Who Moved Abroad and Returned from Abroad, 1992-2007." Retrieved from http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Statistics/19-Abroad_Returns.pdf. Data exclude residents and, for the years 2000-2007, physicians who are not registered with a provincial/ territorial licensing authority and have indicated to the Southam Medical Group that they do not wish to have their information published. Data includes physicians who provide both clinical and/or non-clinical services. Ontario data in 2002 does not reflect four of 12 monthly updates (Sept.-Dec. 2002) from the College of Physicians and Surgeons of Ontario. Original Sources: Supply, Distribution and Migration of Canadian Physicians, 1986-2004; Southam Medical Database, Canadian Institute for Health Information at http://secure.cihi.ca/; Supply, Distribution and Migration of Canadian Physicians, 2005-2007; Scott's Medical Database, Canadian Institute for Health Information at http://secure.cihi.ca/.

Appendix 3[78]

Patterns of intra-jurisdictional physician migration in Canada 2001-2006





78 Adapted from Jean-Christophe Dumont , Pascal Zurn, Jody Church and Christine Le Thi. (2008). World Health Organization. *International Mobility of Health Professionals and Health Workforce Management in Canada: Myths and Realities.* OECD Health Working Papers #40, 32. Retrieved from http://www.oecd.org/dataoecd/7/59/41590427.pdf. Original source data from CIHI at http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_14_E&cw_topic=14.

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Appendix 4[79,80, 81, 82,83]

Table 5: Provincial/Territorial forms of provisional medical assessment, licensure and registration

Regulatory Body	Assessment/ Licensure/ Registration	Eligibility/Requirements
College of Physicians and Surgeons of Newfound-land and Labrador (CPSNL)	Pre-assessment review of credentials for medical practice	Applicants must apply to CPSNL and have a minimum of one year PG training and may be required to have completed the Medical Council of Canada Evaluating Examination (MCCEE). GPs must obtain the LMCC within three years. Specialists must have a minimum of four years PG training in designated countries or be eligible to be certified by the Royal College, or completed three years PG US training in internal medicine, pediatrics, or ER medicine.
	Clinical Skills Assessment and Training Program	• For applicants ineligible under the pre-assessment review process. • Applicants must complete a two-day assessment program through Memorial U; if they pass they may be recommended to enter a six-month or less training program. After training, IMGs are eligible for provisional licensure. • Applicants must fulfill return to service up to two years.
	Provisional license	• Applicants must be graduates of a school or faculty of medicine listed with the World Health Organization (WHO) or FAIMER/IMED Directory of medical schools. Applicants must have a minimum of one year postgraduate training acceptable to the medical board and may be required to have satisfactorily completed the MCCEE with a score satisfactory to the Medical Board or successfully completed the Medical Council of Canada Qualifying Examination (MCCQE) Part I. Specialists must have completed minimum of four years PG training in designated countries or be eligible to be certified by the Royal College, or completed three years PG US training in internal medicine, pediatrics, or ER medicine. • Applicants must have offer of employment from Regional Health Authority (RHA) in a specific geographical location and this license is not to exceed one year.
	Temporary License	NL Medical Board may issue a temporary full licence or a temporary provisional licence for a period and on terms and conditions established by the board for each person who applies for a licence, provided that the person has a degree in medicine from an approved faculty of medicine and Royal College certification.
	Educational license	Applicants must have completed the MCCEE not more than five years before, passed the MCCQE Pt I, and completed one year of PG clinical training in Canada, US, UK, South Africa, Ireland, Australia, or NZ. Applicants must complete a Memorial University training program.
	Special funded PG positions	These positions are for IMGs and physicians returning from practice. Memorial U offers a limited number of specially funded postgraduate positions in areas of recognized need in the province (separate from Canadian Resident Matching Service (CaRMs).

79 College of Physicians and Surgeons of Newfoundland and Labrador. http://www.nmb.ca/; College of Physicians and Surgeons of Newfoundland and Labrador. http://www.nmb.ca/; College of Physicians and Surgeons of Prince Edward Island. http://www.cpspei.ca/; College of Physicians and Surgeons of Nova Scotia. http://www.cpsns.ns.ca/; College of Physicians and Surgeons of New Brunswick. http://www.cpsnb.org/; Collège des Médecins du Québec. http://www.cmq.org/; College of Physicians and Surgeons of Ontario. http://www.cpso.on.ca/; College of Physicians and Surgeons of Manitoba. http://www.cpsm.mb.ca/; College of Physicians and Surgeons of Saskatchewan. http://www.quadrant.net/cpss/; College of Physicians and Surgeons of Alberta. http://www.cpsa.ab.ca/home/home.asp; College of Physicians and Surgeons of British Columbia. https://www.cpsbc.ca/; Yukon Medical Council. http://www.yukonmedicalcouncil.ca/; Health and Social Services, Government of the Northwest Territories. http://www.hlthss.gov.nt.ca/; Health and Social Services, Government of Nunavut. http://www.gov.nu.ca/health/.

80 World Health Organization, op. cit., 102-111.

81 Mary Colbran-Smith, op. cit., 6-23.

82 Canadian Information Centre for International Medical Graduates. Retrieved from http://www.img-canada.ca/en/index.html.

83 It should be noted that this Appendix outlines educational and training requirements as well as certain conditions of assessment, licensure and registration in each jurisdiction; it does not discuss other additional requirements jurisdictions may have such as language proficiency, criminal background checks, etc.

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Regulatory Body	Assessment/ Licensure/ Registration	Eligibility/Requirements
College of Physicians and Surgeons of Prince Edward Island (CPSPEI)	IMG assessment	There is no program specifically for IMGs in PEI; CPSPEI processes and reviews each applicant individually and makes decisions regarding licensure. IMGs trained outside of North America must hold a medical degree conferred by a medical school listed in FAIMER/IMED and pass the MCCEE prior to attempting MCCQE Pt I and Pt II.
	Temporary and limited register	GP applicants require a medical degree approved by the WHO, the MCCEE (except for short-term locums) and two years PG training. Applicants must obtain the LMCC within two years and CFPC certification within three years. Specialist must be practicing in their jurisdiction and accepted as a specialist in their originating country, preferably by examination. CPSPEI reviews their training and compares it to the Royal College. There is a yearly review and the sponsorship must be renewed annually.
College of Physicians and Surgeons of Nova Scotia (CPSNS)	Defined license	• For applicants who are not eligible for full, temporary, or education registration and who have a medical degree from an approved school, and approved PG training, e.g., specialist certification in Canada or another country, or two years of PG training plus at least one year of licensed clinical practice experience or one year of PG training plus at least two additional years of licensed clinical practice experience. • Candidates with no Canadian or US licensed practice experience, or US training in an LCME-approved school of medicine, must be interviewed by the Registrar, and have a formal clinical assessment through the provincial Clinician Assessment for Practice Program (CAPP). One of the requirements for a referral to clinical assessment is the MCCQE Pt I. • Applicants must be supported by a fully registered member sponsor. • Registration in the Defined Register may be extended on a yearly basis for applicants eligible to take the CFPC or Royal College certification examinations as long as they remain eligible without further training.
	Temporary license	Applicants must have a medical degree from an approved school, approved PG training and the MCCQE Pt.1. They must be employed full-time either in the public service of Nova Scotia at the request of the Minister of Health, or in clinical, teaching or research duties at Dalhousie University at the request of the Dean of Medicine.
	Educational license	For all applicants in residency training or fellowship training in a PG training program in NS.
College of Physicians and Surgeons of New Brunswick (CPSNB)	Regulated license	For applicants who do not hold the LMCC but may be eligible for full licensure if they are certified by the CFPC, the Royal College, or eligible for licensure in Quebec, Maine, or another US jurisdiction.
	Public service license (restricted)	Applicable in very limited circumstances for some IMGs without Canadian or US credentials who may be eligible if employed by a Regional Health Authority, similar institution, or the NB government. There are no specific requirements for such licensure and each applicant is considered on an individual basis.
Collège des Médecins du Québec (CMQ)	Restrictive permit	Applicants have a medical degree from a WHO-approved school and the MCCEE and undergo an evaluation period. Applicants must satisfy the CMQ that they are qualified to practice medicine and fulfill a staffing need identified by the Ministry of Health and Social Services.
College of Physicians and Surgeons of Ontario (CPSO)	Restricted certificate	Time-limited restricted certificates of registration are issued, in certain circumstances, to individuals who have not successfully completed all of the MCC exam requirements. Physicians are supervised until they are eligible to write these exams or until the certificate expires.
	Registration through practice assessment	• Open to both Canadian-trained and IMG applicants who are not certified as specialists, who have their clinical skills assessed. IMGs applicants must have at least five years of clinical experience and be currently practicing in a jurisdiction outside of Ontario in Canada or the US. Candidates must complete the MCCQE and achieve Royal College or CFPC certification within five years. • IMGs receive funding in exchange for five years return of service in an underserviced area.

Regulatory Body	Assessment/ Licensure/ Registration	Eligibility/Requirements
	IMG Ontario	IMGs must go through an 8-12 week assessment to ensure competencies (either GP or specialty medicine).
	Repatriation	For graduates of Canadian, US or international medical schools who have completed postgraduate training outside of Canada and require up to two years additional training to meet Royal College certification requirements. Graduates must practice in an underserviced area for a duration equal to the length of Ontario training received.
	Alternative pathways to registration 1-4	As of December 1, 2008, these new pathways are available for the following groups of physicians: 1. Physicians with a Canadian medical degree and postgraduate training without Royal College or CFPC certification; 2. International medical graduates with Canadian postgraduate training without Royal College or CFPC certification and who are practising independently in Canada; 3. Physicians with a Canadian or US medical degree with US postgraduate training and certification; and 4. IMGs with US postgraduate training and certification. • Applicants through pathways 3 and 4 must practice with a mentor or supervisor until they have successfully completed an assessment. Applicants must undergo an assessment after completing a minimum of one year of practice. • This certificate of registration expires after 18 months, but can be renewed with or without additional terms or conditions.
	Alternative pathways to registration 5-6 (not yet approved)	Two additional pathways were circulated for consultation: 1. Non-family medicine specialist IMGs with postgraduate training and certification approved by the Royal College; and 2. Physicians with a medical degree from an unapproved jurisdiction with postgraduate training that has not been approved by the Royal College and who are practising independently in Canada. • Applicants through pathway 5 must practice with a supervisor until they have successfully completed an assessment. They must complete the MCCQE Pt. 2 during the term of the certificate if they have not previously completed it. In addition, applicants must undergo an assessment after completing a minimum of one year of practice in Ontario. • Applicants through pathway 6 must practice with a supervisor until they have successfully completed an assessment and undergo an assessment after completing a minimum of one year of practice in Ontario. • This certificate of registration expires after 18 months, but can be renewed with or without additional terms or conditions.
College of Physicians and Surgeons of Manitoba (CPSM)	Conditional registration	• Applicants must be graduates from an approved faculty of medicine, have passed MCCEE, or Pt I or Pt II, or the LMCC, and completed an assessment process acceptable to the CPSM. • Applicants must also have one of the following: two years PG clinical training acceptable to CPSM; one year PG clinical training acceptable to the CPSM and at least three years practice experience in the preceding five years and completed an orientation program acceptable to the CPSM; the highest qualification in a specialty field where the length of training is of equal duration to that required by the Royal College; or two years of PG clinical training acceptable to the CPSM. If applicants are eligible for exams by the Royal College, CFPC, or US Specialty Boards, they are exempt from these four criteria. • These licenses are limited to specified community or practice setting.
	Temporary registration	• Applicants must be previously registered in Manitoba or another Canadian jurisdiction. • Limited to a specified community or practice setting.

Regulatory Body	Assessment/ Licensure/ Registration	Eligibility/Requirements
College of Physicians and Surgeons of Saskatchewan (CPSS)	Provisional license	• GP applicants must have two years of approved PG training, and either full licensure in country of training, or pass standing in the MCCEE; they must write the MCCEE within the next opportunity and pass within two years, the MCCQE Pt 1 within four years and MCCQE Pt 2 within five years. They are eligible for full license if they pass the LMCC. • Specialists must obtain Royal College certification within three years, and the LMCC within five years. • Both GPs and specialists must commit to remain in a named SK community for three years.
	Temporary license	• GP applicants must have 24 months approved PG training, and either full licensure in country of training, or the MCCEE, United States Medical Licensing Examination® (USMLE) or the Federal Licensing Examination (FLEX) (US); they may be eligible for a temporary, unsupervised license. • GP applicants with 12 months approved PG training may be eligible for a temporary, supervised license. • Specialist applicants must have a specialty designation from Canada, US, UK, Ireland, South Africa, Australia or NZ acceptable to the CPSS and either full registration with the regulatory body granting the qualification or MCCEE, USMLE, or FLEX. • These licenses are limited to 12 months and generally not extended or renewed. Physicians must be sponsored by a physician who has full or provisional licensure with the CPSS.
	Special license	• Limited to psychiatrists, oncologists and medical health officers who work for various government agencies. Their employment must be requested by the Minister of Health and these licenses are only valid for these employers. Applicants who are not eligible for Royal College certification, but who meet other criteria must agree to take an exam in their specialty when it becomes available, have undergone an assessment of their skills and knowledge, and attain the LMCC within five years. • Applicants must commit to a SK community for three years.
College of Physicians and Surgeons of Alberta (CPSA)	Conditional restricted license, special register part 1 or Part 2	• Applicants must have an acceptable medical degree and hold the LMCC. Family physicians must have completed two years approved training and specialists must have completed PG specialty training similar in training and duration to Canadian program. • These licenses are geographically restricted to a specified community with medical need. Applicants must pass preliminary assessment to determine preparedness to practice in AB; this may be waived if the applicant has previous Canadian practice experience or will be in a supervised academic setting. The first three months of license is under supervised integration report of physician's satisfactory performance in practice from colleagues may be required. These licenses have no time restrictions.
	Provisional restricted license (Special Register, Part 5)	• Applicants must have an acceptable medical degree. GPs must have completed two years of approved training. Specialists must have completed PG specialty training similar to a Canadian program. • These licenses are subject to geographic restriction to a specified community designated by the Minister of Health as having an emergency need for medical services. Applicants must be sponsored by a regional health authority and pass a preliminary assessment to determine preparedness to practice in AB; this may be waived if the applicant has previous Canadian practice experience or will be in a supervised academic setting. The first three months of license is under supervised integration, and CPSA may require a report of physician's satisfactory performance in practice from colleagues. Registration is for 30 months and subject to renewal.
College of Physicians and Surgeons of British Columbia (CPSBC)	Temporary registration	• Applicants must be graduates in medicine from an approved medical school. • These licenses are for IMGs to provide medical services in underserviced communities unable to attract a suitable Canadian applicant. Once working on a temporary license, physicians are expected to aspire to complete requirements for full licensure if they stay in BC. GPs must have completed at least two years approved PG training; CPSBC has the discretion to determine if the applicant's training is approved. These physicians must be deemed eligible to write LMCC exams. Specialists must have successfully completed at least the first portion of the MCCEE and be eligible to write Royal College exams. US-trained specialists must be board-certified in the US.

Regulatory Body	Assessment/ Licensure/ Registration	Eligibility/Requirements
Yukon Medical Council (YMC)	Temporary register	For applicants who are non-residents/locum physicians practicing in the territory for three months or less. Applicants must have an acceptable medical degree, the LMCC, and Royal College or CFPC certification, or be a graduate of a medical school from a country other than Canada, two years of PG training, one year of which must be within Canada or the US within a recognized medical school or residency.
	Limited register	For applicants who have some restriction on their license or who are specializing in a particular field. Applicants must have an acceptable medical degree, the LMCC, and Royal College certification.
	Special license	For applicants who have been offered a position in the Yukon, and the Minister of Health and Social Services has stated in writing that a demonstrated need for the special register exists. Applicants must have an acceptable medical degree (WHO), the LMCC, Pt.1, and at least one year of satisfactory PG training. These licenses are valid for three months to five years (to be determined by the Minister of Health and Social Services) and may not be renewed or extended.
Health and Social Services, Government of the Northwest Territories (HSS)	Limited practice register	For applicants doing locums tenens. Permits are for three months.
	Education register	For applicants who are undergraduate and graduate students currently enrolled in approved medical schools and undertaking experience of a limited duration in the Territories.
Health and Social Services, Government of Nunavut (HSS)	Temporary register (Medical Practice Permit) (Limited Practice Permit) (Medical Research Permit)	• For applicants who are registered to practice for a specified period of time with terms and conditions. Applicants must be registered or eligible to be registered in another province. • Applicants should be registered or eligible to be registered in another province, hold the LMCC and have acceptable PG training (GP or specialist) and, if a specialist, certification.
	Education register	For undergraduate applicants and graduate students currently enrolled in approved medical schools and undertaking experience of a limited duration in the Territories.

Compilation by A. Leo, Senior Policy Analyst, Royal College of Physicians and Surgeons, November 2008

Appendix 5

The Royal College of Physicians and Surgeons of Canada
Le Collège royal des médecins et chirurgiens du Canada

December 5, 2008

Federal, Provincial and Territorial Ministers of Health
Federal, Provincial and Territorial Ministers of Labour

Dear Ministers,

We write to commend the objectives under the proposed July 2008 amendments to the Agreement on Internal Trade (AIT) to reduce barriers to the free mobility of qualified workers across provinces and territories, which will serve both workers and Canadians alike. According to these amendments, by the summer of 2009, mutual recognition of occupational credentials will exist in all provinces and territories and "any exceptions to full labour-market mobility will have to be clearly identified and justified as necessary to meet a legitimate objective such as the protection of public health or safety."

The Royal College welcomes measures to ensure full labour mobility for fully licensed physicians. However, we are concerned by the possibility that the AIT amendments as currently written may erode the standard of care provided by physicians and worsen both access to care as well as the continuity of care. These concerns are grounded on a number of factors:

- ***Erosion of quality care***. Provincial and territorial regulatory authorities are responsible for ensuring that physicians licensed to practice within their respective jurisdictions are competent and adequately trained to provide safe, high-quality care. The proposed AIT amendments raise legitimate concerns about the ability of all jurisdictions to fulfill their duty to "protect the public" by severely limiting their ability to ascertain the competency of physicians wishing to move to their respective jurisdictions.

- These concerns are based on a number of elements, including the need for jurisdictions to demonstrate that additional requirements are not, for example, barriers to mobility instead of legitimate checks and balances in light of variations in education and credentials underlying provisional licenses across jurisdictions within Canada.

- While provisionally licensed physicians are essential to meeting the needs of Canadians, particularly in rural and remote areas, provincial and territorial regulators restrict the activities of these physicians to ensure the provision of safe, quality care. Although there is some indication that under the proposed draft wording for these amendments—still subject to ongoing negotiations and Ministerial approval—provincial and territorial regulators will be required to assess provisional medical licenses, many questions remain concerning how this may be accomplished, which merit further discussion.

- In addition, we are concerned that the ability of regulators to address issues concerning any physician who may not practice to the highest standard of care due to ethical transgressions, issues of competency, scope of practice and appropriateness of training, etc., will be circumscribed by these amendments.

- ***Worsening of access to care and continuity of care***. While it must be emphasized that the Royal College does not view licensure as a primary method to ensure either appropriate physician supply or the right mix of physician skills to meet the needs of Canadians across jurisdictions, we are concerned that the proposed AIT amendments have significant potential to exacerbate physician maldistribution, especially in rural and remote areas.

- There is considerable evidence that current physician migration patterns within Canada negatively impact smaller, less wealthy jurisdictions, both in terms of recruitment and training costs through significant migration of providers from these areas to larger, wealthier provinces. These patterns of migration raise concerns regarding the accessibility of care both in smaller jurisdictions and in all rural and remote areas across Canada, as well as concern regarding continuity of care in such regions given the correlation between patient satisfaction and a relationship with a long-term physician.

- Without appropriate safeguards, the movement of physicians away from certain provinces and territories and towards these “magnet” provinces might accelerate, increasing the health imbalance between provinces. The possibility of such unintended consequences also merits further discussion.

In conclusion, we respectfully advise that full implementation of these proposed amendments to the AIT with regard to physicians be delayed until concerns raised by the Royal College and other stakeholders are carefully considered and resolved. The Royal College would be pleased to assist with this process in any way that is helpful, including a face-to-face meeting.

The provision of safe, quality patient care depends on the resolution of these issues. We look forward to your response.

Sincerely,

G. William N. Fitzgerald CM, MD, FRCSC
President, The Royal College of Physicians
Physicians and Surgeons of Canada

Dr. Andrew Padmos, FRCPC
CEO, The Royal College of
Physicians and Surgeons of Canada

cc: Members of the Health and Public Policy Committee - The Royal College of Physicians and Surgeons of Canada

Members of the Canadian Medical Forum

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