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The Underutilization Of International Medical Graduates In Ontario and Canada: A Selective Review Of The Existing Literature On The Experiences Of International Medical Graduates In The Context Of Canadian Health Care Policies

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ABSTRACT

This paper will examine the phenomenon of the underutilization of IMGs in Canada and Ontario. Using the existing literature selectively as it relates to the key research questions, it will be argued that health policy initiatives have contributed in diverse ways to the underutilization of IMGs in the health care system, with significant negative impact upon the life experiences of the IMGs and their families. As will be seen, we need to consider how these health policies have been influenced by other factors – such as systemic discrimination, an issue whose importance is suggested in some of the scholarly literature on this topic – that have contributed to this problem as well as to its resistance to policy remediation.

Key Words: International medical graduates (IMGs); Ontario; accreditation

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ACCREDITATION AND INTEGRATION OF FOREIGN-TRAINED MEDICAL PROFESSIONALS IN CANADA

Chapter 1: Introduction

Accreditation and integration of foreign-trained medical professionals in Canada's medical system has been controversial issue for decades among federal and provincial politicians, officials, regional health administrators and professional regulatory bodies, scholars' academics and other key stakeholders. It has only been relatively recently that issues centered around International Medical Graduates (IMGs) in Canada have reached a critical point in the evolution of health policy, planning and in the delivery of medical care in Canada to meet the needs of its rapidly changing population. These key stakeholders in the health sector are looking at how to address the increasing demand for more practicing doctors in Canada, while at the same time ensuring that they maintain quality service by imposing high standards and expectations of all licensed medical practitioners.

A liberal immigration policy and more open minded Canadian health policies and programs have made some progress to meet the needs of Canada's shifting demographic trends that demand an increase of health care delivery in Canada[1]. In the past few decades, Canada has actively sought and recruited émigrés from around the world to come to Canada to begin a new life as a medical professional. Consequently, there have been many articles, journals and research papers and studies to describe the situation and analyze the underlying issues and causes of the (mis)treatment of IMGs in Canada. Many of them have focused on specific parts of the IMG licensing process in their analysis while others have looked at the industry as a

[1] This paper will define "health care delivery" as the ability for the medical industry in Canada to provide an adequate number of family physicians and specialists to care for not only the sick and the ill, but also to meet the increased medical needs of Canada's aging population. This does not negate the fact that Canada's population is also, and will continue to be, culturally diverse.

whole. This literature review shall use the framework of systemic discrimination to further enhance our understanding of the experiences faced by IMGs as IMGs attempt to enter the medical profession upon immigrating to Canada. Lorne Foster's (2008) analysis of Canada's medical industry concluded that it has become an elite group of individuals who have purposely become exclusionary and that has resulted in an institutional disadvantage for non-white, non-European and female medical practitioners. His article, although a social commentary on the medical industry, identified a historical context for the foundation for the treatment of IMGs today. And as a result, he has conclusively identified that because the treatment has a power and control dynamic, and has become an institutional norm, it will therefore, be difficult to change.

His analysis begins historically with Canada in pre-confederation days when the medical practice in Canada was open and many different views and approaches were explored and used to treat sick and ill individuals. However, as the medical industry in Canada evolved certain individuals wanted to control how medicine and health was to be delivered and promoted. Foster (2008) goes on to cite many examples of how these became exclusionary practices. These practices dismissed the pluralistic approach in favour of a singular approach or treatment of a medical condition. This approach was propagated by white men of European origin and continues today as a norm in the Canadian Medical Industry. In adopting his conclusions and conjectures, IMGs will continue to be a marginalized group of individuals who will always have placed upon them policies to ensure they stay oppressed. They will continue to be excluded from mainstream Canadian medical practice, not because of overt racist policies and practices, but because of the systemic issues that have developed over time for the exclusion of particular groups.

Research Project

This research project takes the form of a literature review that will examine the cost

impacts to IMGs, from barriers to their licensure, through an analysis of public policies via government documents and reports, scholarly journals, discussion and commentary by various institutional stakeholders as well as other documented sources. Accordingly, while this paper will not pioneer new avenues of scholarly research in this area, it will critically explore existing documents, theoretical perspectives and commentary on this issue to enable a more nuanced understanding of the costs to IMGs of barriers to their accreditation that have been shaped and informed by systemic discrimination. While there will be focused attention on the experiences of IMGs in this regard, the larger impact of these barriers on our economy in Ontario and Canada will also be explored. As will be seen, this concept of systemic discrimination will be critically employed throughout this paper as a foundation of its analysis.

Theoretical Considerations – Key Concepts

Two related concepts will continually recur throughout this analysis: "discrimination" and, in particular, "systemic discrimination". While discrimination has undeniably negative connotations in the popular consciousness, it is important to note that it is not always unlawful to discriminate in Canada. However, it is unlawful in Canada to discriminate against individuals on the basis of criteria such as race, sex, ability, age, religion or belonging to particular minority groups (Vladi, 2007, p. 299). This concept of discrimination is, however, notably distinct from that of systemic discrimination. As defined by Vladi (2007), systemic discrimination is a far more challenging issue to identify and measure as,

> it involves largely unintended or unconscious discrimination where, regardless of the personal views of the people involved, the outcome is that a significantly lower number of women and people of colour are hired than able-bodied white

> males. These outcomes are due to processes and practices in which discriminatory notions have become embedded (Vladi, 2007, p. 299-300).

Systemic discrimination is related to the concept of "labour-market exclusion" as advanced by critics such as Foster to explain the otherwise-inexplicable barriers to foreign-trained professionals having their credentials recognized in Canada. As Foster defines this concept "the difficulties immigrants of colour encounter in the recognition of their foreign credentials can be understood as a systematic process of labour-market exclusion" (Foster, 2008, p. 10). According to this concept, professional elites seek to have their professions continue to reflect their "properties" among which is the value of "race".

Discussion of the concepts of "systemic discrimination" and "labour-market exclusion" also entail discussion of the related concept of "cultural competency". This is an admittedly complex concept, but it illustrates how fluid concepts of systemic discrimination and racism can be to identify in this debate. For example, critics argue that professional regulatory authorities in Canada – such as the College of Physicians and Surgeons of Ontario – are effectively requiring IMGs to internalize the "cultural competency" of a Canadian before being granted approval to practice medicine (Foster, 2008, p. 11). In this analysis, when we discuss systemic discrimination in regard to IMGs we are not simply talking about skin colour or obvious markers, but more nuanced and subtle markers that define an individual as a "Canadian" versus a "foreigner".

This discussion brings the concept of "race" into the debate. "Race" is, it must be admitted, a controversial concept that has been shown to have no actual basis in scientific or biological science. However, it remains an important concept for this paper as it serves as a symbolic vehicle for the values of the dominant culture in societies such as Canada. Accordingly, this paper will explore the concepts of "race" and its relative "Whiteness" not as

biological traits but as “social practices” deeply implicated with privilege and cultural power (Foster, 2008, p. 3). As such, it will be shown how they serve to perpetuate processes of exclusion such as that of systemic discrimination experienced by IMGs (Foster, 2008, p. 10).

Research Questions and Primary Problem

This focus on systemic discrimination as a factor influencing health care workforce policy in Canada is a research dimension that distinguishes this report from other work done on this topic. Indeed, as will be seen, there is surprisingly little discussion – in the literature on this topic – of the role of systemic discrimination in fostering barriers to IMG examination, licensure and practise in the Canadian context. This problem will be explored through two research questions:

1. What role has systemic discrimination played in informing health care policy initiatives that have contributed to the underutilization of IMGs in Canada?
2. What have been the effects of this underutilization on the life experiences of IMGs in Canada?

These questions will enable answering the core research problem that is at the heart of this paper: the costs to IMGs from barriers such as systemic discrimination, to their licensure and professional practice in Canada.

Background

Even though there has been a considerable body of literature on issues related to the accreditation, licensure processes, and integration of foreign-trained medical professionals in Canada’s health care system, it has only been in the last decade that this awareness has enabled more IMGs to enter medical practice, particularly in Ontario. This is surprising to many observers given that the shortage of qualified medical workers to support Canada’s growing

and aging population has been a topic of foremost concern among physicians in Canada since the late 1990s.

The Barer-Stoddart (1992) report, released in 1991, is seen as marking a watershed in health care workforce supply in Canada. This report, commissioned by the provincial, federal and territorial Ministers of Health, argued that the supply of physicians had been increasing in Canada beyond the growth of the population with no justification. While many scholars have since blamed this report for Canada's subsequent physician workforce problems, it should be noted that many stakeholder groups at the time were in agreement on this issue of physician surplus (Chan, 2003, p. 9). Moreover, it should also be pointed out that the Barer-Stoddart (1992) report, was very influential in future health policy planning largely because it gave federal and provincial Ministries of Health a justification for health care cost containment at a time when all governments in Canada were focused on cutting back on their budgets. As a result of this policy shift, the percentage of new practice licenses issued to IMGs in Ontario actually declined – as a proportion of total new licenses – from 21% in 1991 to 14% in 1999 (AIPSO, 2002, p. 3).

As a result, in the same decade when immigration to Ontario consistently increased, there was a significant decrease in the number of IMGs licensed for practice from approximately 25% of the total to 14%. While the Ontario government once actively recruited IMGs abroad, over time it actually began establishing barriers to block IMGs settling in the province. The result of these policy decisions – coinciding with demographic shifts as "baby-boom" physicians in Canada retire in record numbers – has been the creation of a significant gap between supply and demand of medical professionals (AIPSO, 2002, p. 3).

While shifts in health care policy directions are commonplace, this momentous shift resulted in poor planning initiatives and programs. In attempt to rectify this policy of errors, decisions were made by federal and provincial Ministries of Health to supplement Canada's low rate of physician and health worker production and to create programs that would attract more international medical graduates. However, the barriers that were raised after the acceptance of the Barer-Stoddart (1992) report did not quickly come down. As a consequence, critics inside and outside the health care profession began to advance the theory that the barriers that were put in place ostensibly due to the findings of the Barer-Stoddart (1992) report, masked an underlying resistance to integrating non-Canadian (and, in particular, non-White) medical workers into Canada's health care system. This view began to gain more supporters as the decade of the 2000s progressed, and federal and provincial governments found themselves revisiting this issue time and time again and drafting new solutions to remedy this problem of physician shortage.

Consider that as recently as 2010 the Association of International Physicians and Surgeons of Ontario estimated that there were 7,500 IMDs in Ontario – that is, physicians alone, as opposed to a larger population of IMGs – of whom 2,000 had passed all of their qualification exams but were unable to secure a residency spot that is essential for being licensed to practice in Ontario (Keung, 2010). The fact that this excess of underutilized IMGs exists at the same time as Ontario has been experiencing a shortage of qualified health care professionals for some years – and this occurring a decade after official recognition was made of the problem by the Government of Ontario – suggests that the barriers to IMG accreditation and practice are deeply embedded and not subject to conventional solutions to remedy the issue. What this meant was that the problems with IMG accreditation and practice were multi-

causal. For example, there could be issues with obtaining forms, having forms processed, having foreign credentials recognized or getting additional training. With so many problems no single solution was going to fix the problems with the system (Keung, 2010).

It may be argued that this problem has shown itself surprisingly resistant to traditional policy remedies as these were solutions to a problem that was not initially clearly understood or defined. Instead, as this paper will argue, the key problem or issue under discussion here is not a physician shortage but, rather, the role of systemic discrimination in contributing to barriers to IMG licensure and practice in Canada has resulted in a "bottleneck" effect (Keung, 2010).

Paper Structure

The paper is composed of the Introduction, followed by four chapters comprising the main body of the paper, and with the text finishing in the Conclusion.

The Introduction will briefly present the topic under discussion. The major topic is the costs of the underutilization of IMGs in Ontario and Canada with the framework of systemic discrimination. The Introduction will proceed to lay out the research problem to be addressed, as well as primary research questions, theoretical considerations and key concepts. One of the most important concepts will be the concept of systemic discrimination. The introduction concludes with a "road map" describing the contents of each chapter and their relation to the objectives of the paper, as well as the methodology of the paper as a whole.

Chapter 2 will present a detailed background of the issue of the underutilization of IMGs in Canada today with a particular focus on the impact of this underutilization in terms of Ontario and Canadian demographic trends. A major component of this chapter are the Reports and Recommendations presented to policymakers over the course of the past two decades on

the related issues of the supply (or shortage) of qualified health professionals in Canada, and how and if IMGs could fill needed gaps in this workforce.

As will be seen, one of the striking features of the Reports and Recommendation that have critically contributed to the shaping of health care policy in this field is how inaccurate many of these reports have been with respect to issues of the supply of health care professionals. For example, most commentators attribute the initial raising of barriers to IMGs in Canada to widespread acceptance of the 1991 Barer-Stoddart (1992) Report which declared – without substantive justification, as it turned out – that there was an oversupply of physicians in Canada (Chan, 2003, p. 9). This finding provided the justification for cuts in funding for medical school enrolment and radical reductions in IMG intake that, in the view of observers like Keung (2010) contributed to the inadequate supply of physicians and health care professionals that has troubled Canada for the past decade.

It should be noted, however, that many interested stakeholders in the field at the time, supported this view, and even as late as 2002 the Romanow Royal Commission on Health Care was asserting that governments should not increase the number of physicians or IMG licensing, but rather initiate policies and programs to instead, optimize use of existing resources (Chan, 2003, p. 9). Thus, the importance of Chapter 2 lies in how it illustrates the complexity of health care policy in Canada, and how even the well-funded and authoritative observers can still support policy directives that are today regarded as Chan argues, “radically flawed”.

Chapter 3 presents a widespread review of the policy initiatives launched by the federal, provincial and territorial governments in Canada since about 2004 when most governments accepted that their existing policies on IMGs were flawed at the very least and therefore needed to be reviewed. In 2004 a Task Force commissioned by the Ministers of

Health from all provinces, the federal government and territorial governments produced a report – The Report of the Task Force on Licensure of International Medical Graduates – that would transform the policy context in which IMGs were being supported and evaluated in Canada.

In general, Canada's Ministers of Health decided to focus attention on solutions and implementing initiatives to lower barriers. For example, Ontario established the Center for the Evaluation of Health Professionals Educated Abroad (CEHPEA) which is an independent, not-for-profit organization that implemented large scale written and clinical testing of IMGs for licensure in Ontario. Ontario has also created the Office of the Fairness Commissioner which worked with the key regulatory bodies in each profession to ensure that registration procedures were compliant with principles of fairness and transparency. These initiatives are not only described but also critically analyzed in the context of the medical sector in Ontario.

In Chapter 4 the "real" barriers to the integration of IMGs into medical practice in Canada are explored. In particular, this chapter will show that while governments and policymakers are striving to address the underutilization of IMGs through new programs, the actual barriers to IMG remain in place. This reveals that there are still flaws in these new initiatives. For example, CEHPEA in streamlining the licensure of IMGs in Canada; has not been able to overcome the fact that there is still a low acceptance of IMGs into Canadian residency positions. These positions are required to attain the necessary Canadian-based experience before entering into practice themselves.

Chapter 5 illustrates the real human costs of these barriers to accreditation and practice as experienced by IMGs across Canada. I acknowledge that this chapter may appear irrelevant in terms of the overall direction of the paper, which is heavily based in a review of the existing

literature and policies on IMGs, it is important to give "faces" and "voices" to these individuals. Furthermore, it allows us to better understand the consequences of race-informed systemic discrimination on the lives of real people and real families.

I propose that these experiences are critical in giving background to statistics that would otherwise be puzzling and dismissed. For example, Statistics Canada has found that of the foreign-born Canadians who have studied medicine, an "amazing" 33% were not only underemployed but were not even working in health-related fields in Canada (Boyd and Schellenberg, 2008). Of the foreign-born who have studied medicine, only 55% actually ever succeed in practicing it in this country (Boyd and Schellenberg, 2008). The scale of this waste of human potential is remarkable, to say nothing of the financial loss to Canadian citizens from having a larger population of health care providers, and to the Canadian economy of having these highly-trained professionals not participating in the economy to their fullest potential.

This chapter will examine the fact that many IMGs have simply given up, despite their medical talents and abilities, accepting that they are going to be underutilized in Canada, because they are prohibited to practice. As is argued, this decision is actually a highly rational one, and is supported by the array of complex costs- not only licensing costs, but also costs in a family and gender context, as well as in a psychological dimension that IMGs must bear in the long process of licensing and passing through residency to practice in Canada.

Time Span 1991-2012

The time span of the literature review extends back only twenty years, to about the time of the commissioning of the Barer-Stoddart report (1991). While there were IMGs facing challenges of licensure prior to this date, it is generally accepted by all authorities on the subject of health care policy in Canada that the early 1990s marked a shift in policy direction

in terms of a radical reduction in funding for health care education by the federal, provincial and territorial governments of Canada. This reduction coincided with the implementation of radical barriers to IMG entry and practice in Canada. Together, these two policy decisions – which would span much of the 1990s – created a crisis in Canada's health care workforce in the form of a radical shortage of qualified workers that Canadian Ministries of Health have been trying to remedy since around 2002. The obvious solution to this has been to increase the intake of IMGs into Canadian practice. However, this paper's review of policy documents and analyses over the course of the past decade will reveal how government initiatives have not been anywhere nearly as effective as they should be given the clear demand for a larger health care workforce.

Types of Sources/Media Accessed

The types of sources and media accessed for this literature review was determined, in broad measure, by the objectives and the challenges faced in this analysis. For example, while a video may be a non-traditional source for a literature review, the National Film Board of Canada documentary – *Doctors Without Residency (2010)* – was an excellent source as it highlighted the challenges faced in exploring systemic discrimination in regard to IMGs barriers to licensure and practice in Canada. The fact that the film makers were unable to find a single IMG in the province of Quebec – out of thousands – who was willing to go on camera and publicly detail the barriers they face provides proof of the challenges in researching this topic. In other words, such a controversial topic must necessarily need to embrace a wide range of source material as possible and not only scholarly journals.

As noted above, there is a remarkable lack of detailed scholarly study of systemic discrimination in regard to IMGs in Canada. While in the course of research, there were

admittedly a considerable number of articles found in journals on immigration detailing the problems of systemic discrimination faced by immigrants to Canada, however, upon reflection the problems faced by IMGs in Canada were notably distinct. While of course systemic discrimination is systemic discrimination – whether experienced by a taxi driver or a physician – the fact remains that IMGs operate in a very different universe. One is governed by professional regulatory bodies which, as some critics suggest, enforce "labour-market exclusion" in subtle ways while the other experience overt discrimination everyday in their daily life. The fact that there are so few studies of systemic discrimination by IMGs, in contrast to studies of such discrimination by workers in other fields, confirm to the radically different contexts and rules at play. For this reason, this paper chose for a more in-depth approach to the study materials.

Chapter 2: Demographic Trends and Inadequacy of Domestic Physician Supply

To fully understand the complex issue of the underutilization of IMGs in Ontario, and Canada in general, it is first necessary to explain why this issue has preoccupied government and health policy administrators across the country. From the perspective of government policymakers, IMGs are important as they represent a potential solution to a demographic and policy challenge that has confronted policymakers for a generation: demographic trends reveal the inadequacy of domestic sources of physician supply in Canada.

2.1 Ontario Demographic Trends and Health Care Needs

As the latest 2010 data from Citizenship and Immigration Canada reveals, while Ontario received the lion's share of Canada's immigrants in 2010 (118,116 of 280,636 or 42.1%) this proportion has been steadily declining each year since 2001 when Ontario received a record 59.1% of immigrants to Canada (Ontario Ministry of Citizenship and Immigration). While Ontario's proportionate share of new immigrants has been declining, the overall numbers have increased over time as has Ontario's overall population which – in 2010 – was approximately 13.2 million (Ontario Ministry of Finance, 2011). Indeed, according to official 2011 Ontario government estimates, between 2010 to 2036 immigration will account for an incredible 68% of population growth in the province (Ontario Ministry of Finance, 2011).

In the context of this population growth, the Ontario Medical Association has publically declared that Ontario is experiencing such a radical shortage of physicians that, in 2011, it estimates some 2 million Ontarians will not have access to adequate medical care (AIPSO, 2002, p. 3). While this current deficit may be considered unacceptable, all demographic projections with regard to Ontario's aging population suggest that the situation is likely to get much worse in the future if steps are not taken to remedy the situation.

In 2010, the number of seniors aged 65 and older in Ontario numbered approximately 1.8 million or 13.9 percent of the population. Even when one factors in immigration, this proportion is expected to continually increase over the next few decades until – in 2036 – seniors will account for 23.4% of Ontario's population (Ontario Ministry of Finance, 2011). Some policy makers and medical researchers such as Carstairs and Keon (2009), suggest that this demographic shift will – even more than the increase in the Canadian population through immigration – impose demands on our medical system that it may not be able to sustain without radical reform.

According to a 2009 study seniors have consistently remained the most intensive users of our medical system. While they make up approximately 13% of the overall population, they account for one-third of all hospitalizations, and more than one-half of all hospital stays. In terms of our overall health care budget, seniors are responsible for 44 percent of health care expenditures (Carstairs and Keon, 2009, p. 139). Given the demographic projection that Ontario's population will age – together with the fact that practicing physicians who are of "baby boomer" age will be continually retiring in large numbers in the next few years – demand for physicians is likely to outstrip supply in Ontario substantially over the next few decades (Carstairs and Keon, 2009, p. 139). The economic costs to the province of Ontario of attempting to remedy this situation – through, for example, increasing medical school placements, or promoting incentives and grants for medical students and higher pay for physicians etc – will be considerable.

2.2 Canadian Demographic Trends and Health Care Needs

While the available statistics with respect to the underutilization of IMGs in Ontario are undeniably grim, they pale in comparison to statistics on this question with regard to IMGs in

the rest of Canada. In general, these statistics – and the range of white papers and policy documents that reference them – depict one grim fact: there are too few physicians practising medicine in Canada today and, despite Canada's growing and aging population, the proportion of medical professional to population will actually shrink between 2011 and 2020.

The inability of domestic sources of supply to meet the health care needs of Ontario's and Canada's population is evident in recent statistics.. For example, in Canada in 2007, about 1.7 million people – approximately 6% of the population – 12 years of age and older were unable to find a regular physician. By 2010, four years later, this number had only increased (Esmail, 2011, p. 12-13). This increase is particularly noteworthy given that, , it has coincided with a range of policy initiatives on the parts of the federal and provincial governments to increase the numbers of physicians in Canada by increasing medical school enrolment and promoting Canada as a country of settlement to IMGs. Thus, it is not surprising that the Organization of Economic Cooperation and Development (OECD) – in its comparative measure of physician-to-population ratios ranked Canada at number 26 out of 28 developed nations with universal access health care programs (OECD Health Data 2010: October 21, 2010 and Esmail, 2011, p. 12-13).

In the mid-2000s the graduating cohort of Canada's medical schools numbered approximately 1,570 doctors, while 2,500 new doctors were estimated to compensate for retiring physicians and meet the need of population growth (Cornwall, n.d.). It is noteworthy that some years later, in 2011, the physician "deficit" in Canada remained effectively unchanged; with Canada's medical schools graduating approximately 900 fewer doctors annually than was necessary to replace those physicians who retired or emigrated (Esmail, 2011, p. 16).

2.3 Reports, Recommendations Regarding Physician Supply

As the comparative measurement suggests (OECD 2010) there has existed for some years a sizable gap between the growing Canadian population and the comparatively shrinking supply of doctors to meet the health care needs of that population. Ben Chan noted in 2003:

> The adequacy of Canada's physician supply has undergone intense scrutiny over the past four years. Although there was initial skepticsm of claims of a physician shortage, a near-consensus among policy-makers has emerged, that the level of production in the 1990s has been inadequate (Chan, 2003, p. 3).

From a policy perspective, one of the interesting aspects of this "physician shortage" is that it is itself a creation of health care policy. According to Dr. Robert McKendry's Ontario Fact Finding Report (1999) - cited in AIPSO's submission to the Romanow Commission on the Future of Health Care in Canada - the proportion of medical professional of international origin in Ontario actually peaked in the late 1960s when about 25% of new doctors were recruited abroad to come to Canada. By the 1980s there began a gradual shift in public policy to attain "self-sufficiency" in medical practitioners by, in part, establishing barriers to IMGs wishing to settle in Ontario. At the same time, there was increasing concern in health policy circles with respect to the rising costs of health care delivery in Canada (AIPSO, 2002, p. 3).

It was in this policy environment that, in the early 1990s, the Federal/Provincial/Territorial Conference of Deputy Ministers of Health commissioned a review on the issues and policy options for assuring an adequate and appropriate supply of medical services for Canadians. As a result of the review, two health economists, Morris Barer and Greg Stoddart –eventually published a report that was reproduced in the Canadian Medical Association Journal. In this report, the authors argued, that Canada would experience a physician surplus in the near-future. Given this, together with the rising health care costs facing government, the authors recommended – among a range of options - that policies should be put

into place to both limit enrolment in Canadian medical schools and restrict immigration/residency openings for IMGs in Canada (Barer and Stoddart, 1992).

The Barer-Stoddart (1992) discussion paper for the Federal/Provincial/Territorial Conference, Conference of Deputy Ministers of Health is one of the most influential, and contentious documents in the history of Canadian health policy. As the Federal Government of Canada's Commission on the Future of Health Care in Canada noted in 2002, while the Barer-Stoddart paper had over fifty recommendations for change in the Canadian medical system – including in particular an new, integrated approach to health care policy and delivery across the country – many of the key ideas in the paper were ignored by governments (Fooks et al., 2002, p. 1). Indeed, as the Commission notes, Barer-Stoddart calls for attention to issues such as a national approach to medical training and health care organization that were "ignored" in favour of a focus on budget cuts (Fooks et al., 2002, p. 1).

It must be acknowledged that, given the controversy surrounding the Barer-Stoddart discussion paper – or, rather, with regard to the marked decline in the number of physicians in Canada due to funding cuts attributed to the recommendations of Barer-Stoddart (1992) – it is difficult to get a firm sense of the accuracy of the report. As even a brief review of the commentary on this report suggests, there is a measure of scapegoating in representations of this report by policymakers in Health Ministries across Canada. For example, commentators have noted the irony that while Barer-Stoddart (1992) in their report criticize the random nature of health care policy planning in Canada, the recommendations of their report were implemented in the same misguided way. Thus, governments across Canada decided that the authors' call for a 10% cut in medical school enrolment was an easy way to save money. However, Ministers of Health across Canada did not even address Barer's and Stoddart's

broader recommendation that such cuts should ONLY be implemented as part of a broader policy that must take into consideration possibilities for error and future demographic change (Fooks et al. 2002).

However, the practical recommendations provided by Barer-Stoddart (1992) for dealing with the problems of accreditation and integration of foreign-trained medical professionals in Canada served only as the "pretext" for policies implementing health care spending reductions. However, the government only paid these recommendations lip service and did not actually implement them. In the view of the Royal College of Physicians and Surgeons, the outcome of the these policies were not predicted by Barer-Stoddart given that many "factors intervened in the mid-1990s which had profound, unintended impacts on physician supply, including cost containment programs in the health sector and the lengthening of residency training" (Chan, 2003, p. 1). Given that two Royal Commissions on Health Care (the Kirby Commission and the Romanow Commission) disagreed on the very existence of a physician shortage in Canada – the Romanow Commission's view that there was no shortage dominating until repeated lobbying by Canada's health care professions compelled policymakers to re-examine their analyses (Chan, 2003, p. 2-3).

Regardless of one's view of Barer-Stoddart (1992), it is clear that over the course of the 1990s, there were implemented provincial directives mandating lower medical school enrolment as a cost-saving measure (Cornwall, n.d.). Esmail (2011) argues that the increasing gap between the health care needs of the Canadian population, and the supply of physicians to meet these needs, was a problem whose primary genesis actually lay in state health policies:

> Canada's policies restricted the growth rate of the physician-to-population ratio in order to remain at a level that is now below what other nations provide through their...health programs, and below the current demand for physician services in Canada (Esmail, 2011, p. 13).

As it has been documented, the current gap between the number of IMGs that have gone through Canadian medical schools and the number needed by the Canadian population was, in large part, underestimated. Therefore, the health policies and planning that were developed in response by provincial and federal governments were flawed because they were based on inaccurate demographic projections of Canada's need for physicians. Given this, it is only logical to expect that this problem can be remedied by policy initiatives as well. However, despite this gap being a recognized problem for years – and despite the fact that both federal and provincial governments have identified the available population of IMGs in Canada as being an optimal solution to this problem – successive policy initiatives have been unable to address the underutilization of IMGs by the Canadian medical system (Esmail, 2011).

2.4 IMGs: A Valuable Resource to the Economy

In the context of these projections, there is a clear and persistent need for more doctors than the Canadian education system is providing. One obvious source to meet this gap are international medical graduates (IMGs) who have obtained their degrees and clinical experience in other countries.

However, as reported by Nicholas Keung in an article in the *Toronto Star*, the Association of International Physicians and Surgeons of Ontario estimates that there are 7,500 IMDs in Ontario – physicians alone, as opposed to a larger population of IMGs – of whom 2,000 have passed all of their qualification exams but are unable to secure a residency spot that is essential for being licensed to practice in Ontario (Keung, 2010). Indeed, even in terms of specialization the population of underutilized IMGs appear particularly well-suited to meet this shortage. For example, while studies have found large proportions of the population in Ontario cannot find a family doctor (Broten, 2008 and Carstairs, 2009), at the same time family

medicine is much more heavily subscribed among IMGs (45.5%) than among Canadian medical graduates (29.6%) (Szafran et al., 2005, p. 1248).

IMGs also become an obviously valuable resource when we consider the increasing role of immigration in Canada's future, and the need to supply services to immigrant populations whose knowledge of Canada's primary languages/cultures may be inadequate for some time after settlement.

Consider, for example, the fact that the first and fourth most prominent source countries for immigrants to Ontario – rankings that have been consistent over the past five years – are India and Pakistan respectively (Ontario Ministry of Citizenship and Immigration, 2009). Given the consistency of this demographic trend, it is likely that for the immediate future the proportion of Ontario's immigrant population and overall population from the South Asian region will continue to grow.

Yet, as we see in Table 1 (Appendix C, sourced from Boyd and Schellenberg, 2008), IMGs from South Asia are the least likely – of all source regions of IMGs to Ontario – to eventually be allowed to practice medicine in this province. Thus, while Ontario public policy is focused on integrating immigrants by providing services to them in their own languages/culture in order to aid settlement, despite the fact that the largest portion of Ontario's immigrants will be South Asian, IMGs from this area are less likely than IMGs from any other part of the world to be licensed to practice in Ontario.

It is necessary to add to these costs the economic costs to Ontario for immigrants who face barriers to accessing medical care because of language or cultural barriers. The disparity, noted above, between the waves of immigration projected to come from South Asia - and the low likelihood of South Asian IMGs practicing in Ontario – suggests that this problem will

likely increase over time. It should be noticed that the previous point argues that this problem will have sizable and growing economic costs for Ontario as seniors who are reluctant to access services because of perceived barriers will leave chronic conditions untreated until the last moment. Thus, instead of cost-effective preventative care for the growing population of seniors who were immigrants from South Asia...the Ontario government will face cost-intensive emergency care for this growing segment of Ontario's population (Carstairs and Keon, 2009. p. 140-141).

According to Dr. Andre Padmos, chief executive of the Royal College of Physicians and Surgeons of Canada, and quoted in the *Globe and Mail*, at the end of 2011 there were between 6,000 and 10,000 qualified IMGs in Canada who cannot practice medicine – not because of delays in exams or certification – but simply because there are not enough residency positions available in Canada. As cited in the *Globe and Mail*, Dr. Padmos notes that there are actually only slightly more residency positions available than there are medical graduates from Canada's medical schools (Mackrael, 2011). This despite the fact – as noted above – that it is widely recognized that the number of graduates from Canada's medical schools cannot meet the needs of Canada's population for doctors.

2.5 Professional Regulation: College of Physicians and Surgeons of Ontario

In Canada, the Canadian provincial and federal governments do not actually have direct responsibility with respect to the accreditation of IMGs. Instead, for physicians and nurses, entry requirements for the professions – and the legal authority to practice in a particular jurisdiction – are determined by professional regulatory bodies.

In the Canadian context, this issue is complicated by the fact that there are 22 health professions in Canada, and there is no central national regulatory body setting standards for

certification and credential recognition. Instead, IMGs who wish to practice in a particular province must meet the requirements of that province's regulatory body; requirements that can vary from province to province. In Ontario, the College of Physicians and Surgeons of Ontario (CPSO) is the regulatory body delegated by the provincial government to set the requirements for medical practice in the province, and registering physicians for work (Broten, 2008).

While the underlying principle governing the accreditation process in Ontario is that "access to the medical professions must be transparent, objective, impartial and fair" (Broten, 2008, p. 5), studies have found that the system favours Canadian-trained medical graduates over IMGs. In this analysis, it is clear that the current regulatory system has been "ultimately failing the public interest of ensuring that healthcare providers are deployed in ways best to meet the needs of Ontarians" (Broten, 2008, p. 6).

The reasons for this are complex, but compelling arguments have been made by critics such as Foster supporting the view that cultural factors contribute to the resistance of these regulatory institutions to meeting the demands of governments, and the population, for more IMG accreditation. In particular, Foster argues that provincial medical authorities such as the College of Physicians and Surgeons of Ontario (CPSO) are effectively requiring IMGs to internalize the "cultural competency" of Canadian-trained physicians before granting these IMGs approval to practice medicine (Foster, 2008, p. 11).

The concept of "cultural competency" is complex, and touches upon issues related to systemic discrimination which will be discussed at somewhat greater length later in this paper. However, in this paper's discussion of the professional regulations that determine the process of licensure for IMGs in Canada this concept is very important. It allows us to understand not only the rigor of this process, but also the otherwise puzzling fact that many IMGs who pass

the qualifying exam may never succeed in gaining a residency position necessary to attain the Canadian experience that they must have to practice medicine in Canada. As Fidelman notes, this is a lack of success that can be especially puzzling when many residency positions go unfilled (Fidelman, 2007).

Critics such as Foster (2008) argue that:

> …in addition to assessing the value of non-Canadian credentials, the Medical Council of Canada and other medical regulatory authorities in the provinces—supported by federal and provincial legislation—attempt to reproduce the social and cultural integrity of the professional membership by requiring applicants to internalize cultural competency norms specific to the profession as it is practiced in Canada (Foster, 2008, p. 11)

What is meant here by "cultural competency" is essentially the manifestation – in the form of socialized knowledge of medical practice – of the attitudes and "institutionalized cultural familiarity" of "White malestream thought" that dominates both the Canadian medical establishment and its regulatory bodies. As may be expected, many IMGs are unable to internalize this "cultural competency" and so residency positions go unfilled while the institutions that tolerate this situation assert that they are not being discriminatory but rather stringent in their procedures. Thus, regulatory bodies and licensing processes are able to "trivialize their [IMGs] skills and potential contributions to society, all without any reference to race" (Foster, 2008, p. 11). Yet, the outcome for both the IMGs and Canada is the same:

> …the result of global credentialism for Canadian medicine is a racialized, two-tiered occupational structure. Due to this segmented labour market, immigrants suffer from occupational downgrading or de-skilling, and are often forced to switch careers and experience loss of social status (Foster, 2008, p. 12).

As noted above, one of the critical "bottlenecks" in the accreditation process for IMGs in Ontario, and in Canada in general, is the difficulty in obtaining a residency position. Tetchena Bellange (2010) in the film *Doctors without Residency* examines many of the

problems faced by IMGs trying to get positions in Canada. According to Bellange (2010) All would-be medical practitioners in Canada must complete an accredited postgraduate training program – typically referred to as “residency training” – after having successfully passed their qualifying examinations (Bellange, 2010) . This requires that IMGs be matched with an available residency position, and as Bellange (2010) indicates that the problem can best be rectified by increasing funding to enable more residency positions to be opened. However, as noted above, residency positions have often gone unfilled as qualified IMGs have been deemed unsuitable as their medical backgrounds have not been considered relevant to the Canadian context (Bellange, 2010).

Chapter 3: Policy Initiatives on IMGs

In the past decade, the provincial and federal governments have launched a range of policy initiatives to remedy the widely-acknowledged problem of low level accreditation of IMGs in Canada. This stemmed from major issues that became publicly overt such as ineffective access to health care and underutilized IMG's. In 2004, the Federal-Provincial-Territorial Advisory Council on Health Delivery and Health Resources released an influential report: "The Report of the Task Force on Licensure of International Medical Graduates". As the Physician Credential Registry of Canada (2012) indicates in their website, this report recommended that a centralized credentials verification service be implemented to validate the documents required for licensure and maintain a repository of verified credentials. In response, the Medical Council of Canada created the Physician Credentials Registry of Canada (PCRC) to reduce duplication of credentials and provide a single, national repository which all regulatory professional bodies in Canada can easily access in their processes of evaluating and licensing IMGs (Physician Credentials Registry of Canada, 2012).

At the provincial level, governments have cooperated with professional regulatory bodies in efforts to streamline the process of accreditation. For example, in 2007 the Ontario Ministry of Health and Long Term Care initiated the Centre for the Evaluation of Health Professionals Educated Abroad (CEHPEA). This organization was developed in response to complaints by IMGs regarding bottlenecks in the accreditation process. In order to speed up accreditation CEHPEA offers written and clinical assessments for IMGs in two streams – the Family Medicine Stream and the Specialist Stream (CEHPEA, 2010-2011). Their results have been documented in their annual report.(CEHPEA, 2010-2011 see Appendix B). According to Broten (2008) their programs were intended to "provide standardized evaluation and

orientation services for international medical graduates, allowing them a clear comparison with Canadian competencies" (Broten, 2008, p. 16).

Finally, in response to repeated complaints by both IMGs and independent commentators and scholars that the accreditation process in Ontario was opaque and frequently unfair, in 2007 the Ontario government opened the Office of the Fairness Commissioner to ensure the implementation of the Fair Access to Regulated Professions Act (FARPA, 2006 – See Appendix A.). The FARPA was intended by the government of Ontario to ensure that individuals applying for recognition by regulated professions encounter registration procedures that are "transparent, objective, impartial and fair" (Broten, 2008, p. 5). However, as Broten has pointed out, terms such as "fair" may sound well and good to the general public, but actually have no legal definition without clearly-defined benchmarks for what would be considered "fair" in a given context. Moreover, as Broten notes, "any objective analysis of the registration process for doctors makes it clear that the current process is substantively unfair when it comes to assessing the qualifications of internationally trained doctors". By this Broten (2008) suggests that IMGs have to do more to be accredited then Canadian trained doctors. They have to have additional training, take additional courses, take additional examinations and spend more to get accredited then Canadian trained doctors. In effect they have to put substantively more time and energy into getting accredited than Canadian trained doctors (Broten, 2008, p. 5).

Indeed, the above policy initiatives share a common underlying inadequacy: more attention needs to be paid to the residency issues that do not address the fact that the key bottleneck in the integration of IMGs in Canada occurs at the "residency training" stage. Each policy event will be discussed in detail in order to demonstrate how the focus on residency

training is the major problem. These issues are illustrated in Bellange's (2010) film *Doctors Without Residency*. Bellange (2010) argues that "cultural factors" often seem to come into play when medical administrators select which qualified candidates will fill a particular residency positions. While the policy initiatives noted above have made admirable efforts to streamline the process of accreditation and provide more information and services for IMGs in Canada, the fact that they avoid directly addressing this bottleneck issue is significant and deserves attention. It may be speculated that provincial governments are unwilling to directly challenge their professional regulatory bodies on the question of the value these bodies seem to place on "cultural competency" in matching (or not) IMGs to residency positions (Bellange, 2010).

3.1 The Task Force

In June 2002 the Federal-Provincial-Territorial Advisory Council on Health Delivery and Health Resources established a task force that was given the mandate of enhancing the integration of qualified international medical graduates into the Canadian health care system. Two years later, in February 2004, the *Canadian Task Force on Licensure of International Medical Graduates* (2004) released its report which was accepted by the ministers of health of Canada's provinces and territories, along with the federal government. This report contained six key recommendations which are detailed below, along with descriptions of the initiatives undertaken by the various levels of government – coordinated by the federal International Medical Graduate Implementation Steering Committee – to support better integration of IMGs into the Canadian system.

Recommendation 1: Increase the capacity to assess and prepare International Medical Graduates for licensure.

This recommendation of the task force was arguably the simplest in that it entailed enhancing the capacity of the existing assessment system to accept more IMGs for assessment. This recommendation was implemented through increased funding for assessment and licensure projects by the federal and provincial governments in Eastern Canada and by the Western Alliance for the Assessment of International Physicians which covered the provinces of Western Canada as well as the Territories and the Yukon. Of the IMGs who participated in these projects, some 70% were practicing medicine in Canada by 2008 (Royal College of Physicians and Surgeons of Canada, 2008).

Recommendation 2: Work towards the standardization of licensure requirements across Canada.

To support this recommendation, two national projects were initiated by the Medical Council of Canada. The National Assessment Collaboration (NAC) worked with stakeholders to develop evidence-based criteria for the optimal screening of IMGs seeking licensure. This project was intended to promote fairness and transparency, and eliminate bias as much as possible, from the licensure assessment process. Another project, the Physician Credential Registry of Canada (PCRC) was also later initiated by the MCC to provide a national verification standard for IMG core credentials; in essence, ensuring national consistency in the application of standards to IMG assessment (Royal College of Physicians and Surgeons of Canada, 2008).

Recommendation 3: Expand or develop supports/programs to assist IMGs with the licensure process and requirements in Canada.

Several initiatives were established to support this recommendation, including: (1) the creation of a national website – Canadian Information Centre for International Medical

Graduates – with basic information on licensure, programs and supports; (2) an online self-assessment tool was initiated by the Medical Council of Canada to allow IMGs to evaluate themselves by completely an online knowledge assessment; (3) increased access to the Medical Council of Canada's exams; (4) development of an interactive, web-based learning tool that gives IMGs information on the cultural and communication standards expected for medical practice in Canada.

Arguably, this was the most complex recommendation to implement as it required addressing a myriad of issues that confront IMGs from different countries/cultures in relation to the assessment and licensing process in Canada. In general, the initiatives to support these recommendations are web-based and online; essentially cost-effective means of providing information to as wide a number of IMGs – not only in Canada, but in other countries – regarding their prospects and processes necessary for licensure and practice in Canada (Royal College of Physicians and Surgeons of Canada, 2008).

Recommendation 4: Develop orientation programs to support faculty and physicians working with IMGs.

To support this recommendation, the Association of Faculties of Medicine in Canada developed a multi-media program to assist educators in working with IMGs. This program has been implemented in all 17 medical schools across Canada (Royal College of Physicians and Surgeons of Canada, 2008)).

Recommendation 5: Develop capacity to track and recruit IMGs.

The Association of Faculties of Medicine in Canada developed the IMG Database to implement this recommendation. This tracks IMGs from their beginning of the licensure process through all stages to their practicing medicine in Canada. This tool was desired by

policy makers and The Association of Faculties of Medicine in Canada given the lack of up-to-date statistics regarding IMGs and licensure in Canada. This system's statistics will be publicly available and provided to policy makers to support development of more targeted programs to streamline licensing of qualified IMGs in Canada (Royal College of Physicians and Surgeons of Canada, 2008).

Recommendation 6: Develop a national research agenda, including evaluation of the IMG strategy.

Health Canada has engaged an independent, third-party consulting firm to evaluate all of the projects – including those noted above – it has funded and/or developed to implement the other recommendations of the Task Force. To date, substantial – though not complete – progress has been found on most of the recommendations of the Task Force (Royal College of Physicians and Surgeons of Canada, 2008). That task force was just one of the regulatory bodies, governmental institutions and accrediting bodies trying to address the problems facing IMGs. The next institution to examine is the CEHPEA.

3.2 CEHPEA

The Centre for Evaluation of Health Professionals Educated Abroad (CEHPEA) is a not-for-profit organization, funded by Ontario's Ministry of Health and Long-Term Care, with the mandate of serving as an evaluation and training centre for IMGs. Its examination and training centre is located in downtown Toronto, and can provide large-scale written and clinical exams on-site. CEHPEA also offers assessments for IMGs for direct entry to residency training programs.

The mission of the CEHPEA has evolved over the time span of its short organizational life. Indeed, while the CEHPEA's website declares their "mandate is to serve solely as an

evaluation and training centre" for IMGs, their 2012 Annual Report notes that due to their success with IMGs they have "been asked to apply our expertise in other areas" as with the recently launched initiative for Quality Assurance Practice OSCE for Ontario's nurses (CEHPEA Annual Report, 2012, p. 3).

While it is not surprising that an organization such as CEHPEA should seek to build on its success by extending services into other areas, the extent to which this may impact its delivery of assessment and evaluation services for IMGs remains unclear. However, if we review the organization's annual reports, the results suggest some cause for concern.

Contrast, for example, CEHPEA's first Annual Report (2007-08) with its most current Annual Report (2011-12). While the 2007-08 Annual Report is a valuable resource tool, filled with statistics and detailed descriptions of the assessment services provided to IMGs, the 2011-12 Annual Report has notably less statistics and descriptions of services, and more pictures and interviews with CEHPEA staff. It seems more marketing than information-oriented, and celebrates the CEHPEA organization rather than its mission.

In the 2007-08 Annual Report, it is reported that CEHPEA conducted 725 IMG assessments in 2007, of which 454 were clinical examination assessments, 107 were specialized clinical examination assessments, and 164 were specialized written examinations. However, it is impossible to know – from the 2011-12 Annual Report, how many assessments were conducted in the year in question. Instead of the range of statistics in the earlier report, CEHPEA's latest report focuses on biographies and quotes from the executive and staff members of CEHPEA, with occasional brief statistics – such as on Top Ten countries of origin of IMGs assessed at CEHPEA - scattered through the report (at the tops of pages 11, 12, 13, 17 and 27) as if these statistics served a decorative rather than informational purpose. The focus of

CEHPEA seems to have shifted somewhat from its original focus solely on providing assessment services for IMGs.

This being said, when CEHPEA's six Annual Reports since the foundation of the organization are considered in their entirety, we can understand the importance of this organization to IMGs in Ontario and Canada in general. A critical reading of the statistics provided suggests that, as CEHPEA matures, it seems a significant shift is also occurring in health policy in Ontario with regard to IMGs.

In the 2008-09 Annual Report, it is indicated that over 1,100 assessments were offered to IMGs in Ontario in the five years prior to CEHPEA's existence. That same year marked the high point of assessments conducted by CEHPEA for IMGs, with some 739 done; a modest increase from 725 the year the organization began (CEHPEA Annual Report, 2007-08, p. 7; Annual Report, 2008-09, p. 9). By the following year, this number had dropped significantly to 492 (CEHPEA Annual Report, 2009-2010, p. 7), rising to 522 in 2010-2011 (CEHPEA Annual Report, 2010-2011, p. 8) and to a less precise number of "close to 600" (Annual Report, 2011-2012, p. 11). Thus, in the five years of its existence, CEHPEA has conducted assessments on approximately 3050 IMGs; almost 3 times the number of assessments offered in the five years prior to the founding of CEHPEA. By any measure, the organization has performed admirably in its core mandate of providing assessment and training for IMGs to enhance the pool of qualified medical personnel for the Ontario health care system.

CEHPEA's Annual Reports also provide us with critical insights into IMGs in Canada that seem not to be replicated anywhere else. For example, in its 2009-10 Annual Report, CEHPEA reveals that IMGs account for a remarkable 25% of the total physician workforce in Ontario! (CEHPEA Annual Report, 2009-10, p. 3). While CEHPEA's source for this statistic is

unknown, this is a remarkable number when we consider the statistic from the Annual Report the year prior that Ontario absorbs more IMGs than all the other provinces of Canada combined (CEHPEA Annual Report, 2008-09, p. 5). Again, the source for this number is unknown; however, it is unlikely that the CEHPEA would be making these numbers of out thin air.

These statistics, however, raise as more questions than they answer, and beg for a more detailed cross-Canada analysis. Why should Ontario absorb more IMGs than the rest of Canada combined, when its population vis-a-vis the rest of Canada is not proportionate? When did the IMGs assume such a sizable proportion of Ontario's physician workforce?

CEHPEA's statistics on assessments, and notably the seeming decline in IMGs assessed over time, also beg for more study. What has caused this marked decline, most notably between 2008-09 and 2009-10? Moreover, why in the face of this decline, has CEHPEA begun "branching out" to offer services to non-IMGs? Has the available number of IMGs seeking assessments been drying up?

3.3 FARPA

The Fair Access to Regulated Professions Act (FARPA) – later amended to Fair Access to Regulated Professions and Compulsory Trades Act - was a bill passed in the province of Ontario in 2006 with the intention of ensuring that in regulated professions and trades, individuals who are applying for registration in these professions will be evaluated and/or registered by practices that are transparent, objective, impartial and fair. This legislation applies to a range of professions, including such areas as: accounting; forestry; early childhood education; teachers; lawyers; engineers; land surveyors; social workers etc (FARPA, 2006).

The origins of this Ontario legislation extend back to the 1980s when Ontario's Task Force on Access to Professions and Trades found that discriminatory practices were commonplace in the registration and licensing processes of many professions. The Task Force concluded that "broad structural solutions were needed to remove systemic barriers to the professions" (Office of the Fairness Commissioner of Ontario, 2012).

This finding with respect to "systemic barriers to the professions" across Ontario became a focus of government action given the anticipated decline in Ontario's birth rate and workforce, and the clear and present need for immigrants to support continued economic growth in the province (Office of the Fairness Commissioner of Ontario, 2012). It should be noted that the workers in health care professions are generally excluded from this Act, as they are covered under different legislation. However, this Act is important for IMGs as it established an Office of the Fairness Commissioner for Ontario. While FARPA does not actually cover the health care professions, it modifies the legislation that does address these professions – the Regulated Health Professions Act – stating that registration assessment and licensing in the health professions must be "transparent, objective, impartial and fair", and assigning the Fairness Commissioner the responsibility for enforcing this across the province (Office of the Fairness Commissioner for Ontario, 2012).

For IMGs, for example, the Office of the Fairness Commissioner requires that Ontario's College of Physicians and Surgeons review their registration procedures for internationally-trained medical graduates, submit reports about these procedures to the Office of the Fairness Commissioner, and then submit to audits on those reports. Should the Fairness Commission decide that a professional body is not acting with fairness and respect towards internationally-trained applicants, it can issue a non-compliance order with regard to that

professional body, and then forward this to the relevant Ministry for further action. For example, should the College of Physicians and Surgeons be found in non-compliance with the Fairness Act, the Commissioner would pass an order of non-compliance to the Ministry of Health and Long-Term Care which would then have the legal authority to address this non-compliance with the professional body (Office of the Fairness Commissioner of Ontario Mandate, 2012).

It should be emphasized that the Office of the Fairness Commissioner was not established to help IMGs or other internationally-trained immigrants attain their professional credentials in Canada. It is not a professional regulatory or registration body. The setting up of this office has been criticized by Broten (2008) who notes that the term "fair" actually has no legal meaning. (p. 5). Ironically, while the Fairness Commissioner was established in order to address complaints by internationally-trained professionals that they were often subject to arbitrary or subject procedures in their licensure and/or registration processes in Ontario, the solution is to apply an equally subjective term – "fair" – as a basis to assess a professional body's level of compliance. In other words the FARPA is an Act that seems to be saying a lot. However, on closer analysis it does not do much as it lacks definitive criteria for the terminology it uses. Therefore, the Act does nothing to regulatory bodies that are systematically discriminating against internationally-trained professionals.

Chapter 4: Barriers to IMG Integration

In a study on IMG settlement, Foster has argued that restrictions on IMG settlement and practice have nothing to do with the needs of the population or economic costs but to be a form of "labour-market exclusion" which has often taken the form of barriers to non-white physicians (Foster, 2008, p. 10). This concept of "labour-market exclusion" is important, as it touches upon the systemic nature of the barriers faced by IMGs in Canada. Foster contends that with regard to credentialism in general:

> the difficulties immigrants of colour encounter in the recognition of their foreign credentials can be understood as a systematic process of labour-market exclusion....Those who hold a valued position may have an interest in defining it in such a way that it cannot be occupied by anyone other than the possessors of properties identical to their own (Foster, 2008, p. 10).

The above quote is particularly important as it illustrates how difficult it can be to identify and challenge systemic barriers to IMG integration and accreditation when these barriers do not immediately present themselves as obviously discriminatory to any particular group. Instead, as Foster argues persuasively, while the concept of "race" as a differentiating criterion has been almost universally undermined in Canadian society, nonetheless "race" remains embedded in values of the dominant culture and perpetuates privilege and disadvantage in our society" (Foster, 2008, p. 10). Thus, while the regulations governing the recognition of IMG credentials, the exams that they must pass, and the interviews they must experience for residency positions may never seem overtly discriminatory in any way, in subtle ways these processes can incorporate and perpetuate the White, male values of the Canadian medical establishment. IMGs may find that they are effectively excluded from participation in the labour market for medical professionals in Canada – and from competition with native-

born Canadian medical graduates – because of matters such as interpersonal communication and paralanguage skills (Violato, Watt and Lake, 2011).

The consequence of these barriers, in the province of Ontario, was a steady decline in the number of IMGs settling and attempting to attain accreditation in the 1990s. The percentage of new practice licenses issued to IMGs in Ontario actually declined – as a proportion of total new licenses – from 21% in 1991 to 14% in 1999 (AIPSO, 2002, p. 3). Thus, in the last quarter of the twentieth century, when immigration to Ontario increased across the board, there was a significant decrease in the number of IMGs licensed for practice from approximately 25% of the total to 14%. While the Ontario government once actively recruited IMGs abroad, over time it actually began establishing barriers to block IMGs settling in the province. The result of these policy decisions – coinciding with demographic shifts as "baby-boom" physicians in Canada retire in record numbers – has been the creation of a disastrous gap between supply and demand of medical professionals (AIPSO, 2002, p. 3).

4.1 The Problem of Residency Experience

Scholars argue that while assessing the origins of institutional and professional biases against IMGs is difficult, there exists considerable evidence that biases – in terms of not only race and ethnicity but also gender – are negatively impacting the integration of IMGs in Ontario and Canada (Foster, 2008, p. 10). These biases can not only reinforce financial costs by delaying or completely blocking IMG's professional practice (Fidelman, 2007), but they can have significant emotional costs for the IMGs themselves (Fiscella Roman-Diaz, Lue and Botelho, 1997, p. 116). Indeed, studies have found that even in the post-licensure practice stage native-born physicians are actually less likely to refer patients to IMGs than to non-IMGs (Kinchen, Cooper, Wang, Levine, and Powe, 2004, p. 754-5).

Foster (2008) illustrates the complex challenges in understanding the underlying factors that contribute to the underutilization of IMGs in Canada. Foster's article opens, with reference to Canada's "fundamental immigration paradox in the field of medicine: While millions of Canadians can't find a doctor, thousands of foreign physicians can't get a license to practice in Canada" (Foster, 2008, p. 1). As we have seen in the course of this literature review, this paradox has played a critical role in determining the opportunities and experiences of IMGs in Ontario and Canada over the past two decades. Foster argues that the Canadian medical profession is regulated to the disadvantage of IMGs and, in particular, IMGs who are "non-European and non-White immigrant practitioners" (Foster, 2008, p. 1). This manifests itself most directly in the phenomenon of "Credentialism" and the disregard of the training and academic credentials of IMGs of non-European descent for reasons unconnected with qualifications in any respect. Instead, Foster contends that dialectics of culture and power – race and "Whiteness" being conceived not as biological traits but as "social practices" determined by privilege and cultural power (Foster, 2008, p. 3) – have subtly shaped the Canadian medical establishment and its institutions. The term "subtly" is important to note in this regard, as a key point of Foster's argument is that issues of race and race-based discrimination are subsumed underneath the regulations and policies of Canada's medical institutions and policies such that clear identification of discrimination becomes highly challenging:

> Credentialism and licensing procedures can thus facilitate the cultural exclusion of immigrant practitioners, circumscribe their identity as high-risk interlopers, and trivialize their skills and potential contributions to society, all without any reference to race (Foster, 2008, p. 11).

It should be noted that this "subtle" discrimination does not end with credentialism at the licensing process. One study of the referral practices of primary care medical physicians in

the United States found that even in the post-licensure practice stage native-born physicians are actually less likely to refer patients to IMGs than to non-IMGs. All other variables being equal, it appears that physicians' knowledge of the background of the IMG specialist as a foreign-trained immigrant is correlated with a statistically-significant lower likelihood of the physician referring a patient to that specialist. This is a matter of clear concern to health care systems as it could lead to patients being referred to less-qualified specialists solely on the basis of that specialist being native-born (Kinchen, Cooper, Wang, Levine, and Powe, 2004, p. 754-5).

Even given such studies, it is very difficult to clearly attribute discrimination as a contributing factor to the barriers facing IMGs. For example, if we look at the issue of IMGs attaining residency experience – and the question of who are the "gatekeepers" of this process – we can see the challenge Foster outlines in attributing discrimination as a contributing factor in this debate. Consider, for example, the situation in Quebec in 2007 when

1) 800,000 Quebecers could not find a family physician, and
2) 200 IMGs have passed all qualifying exams and were deemed qualified by Quebec's regulatory bodies to practice medicine in Quebec, yet were not able to find a residency position to gain Canadian experience, yet
3) 87 residency positions remained vacant and unfilled in the province's teaching hospitals. (Fidelman, 2007)

The above series of points clearly illustrate the "paradox" of Canadian health care policy and regulation with regard to IMGs. According to Fidelman (2007) the situation in Quebec is so stark that it has stimulated considerable attention in the media, leading the "College des Medecins du Quebec" to publicly deny that it was blocking IMGs from practising medicine. College president Yves Lamontagne declared: "Our role is to protect the public. We

have to make sure each candidate has been adequately trained and is fully competent. There's absolutely no discrimination" (Fidelman, 2007). He continues to argue that Quebec's medical establishment ensures that no IMG may slip into Quebec's system with false credentials.

The situation facing IMGs in Ontario is very similar to that noted in Quebec by Fidelman (2007). It is difficult to reconcile the existence of these thousands of qualified (by Ontario's own exam system) and unemployed physicians with the consensus – not only in the scholarly literature, but also in policy documents by the provincial and federal governments, as well as the medical profession's leading journals - that Ontario and Canada needs thousands of physicians and that many citizens cannot find a family doctor (Broten, 2008; Carstairs and Keon, 2009).

4.2 IMG's and Systemic Discrimination

When we consider these numbers from the perspective of IMGs, we can understand something of their frustration and confusion. In this respect, the issue of systemic discrimination emerges from this review of the existing literature.

It is important, in this regard, to clearly define "systemic discrimination" and to differentiate between this concept and "discrimination" in general. In the context of a work or social environment, to discriminate between individuals means to treat them differently in terms of certain attributed criteria. While discrimination in general in Canada is not always unlawful, it is illegal to discriminate between individuals in Canada on the basis of race, age, sex, religion or belonging to designated minority groups (Vladi, 2007, p. 299). In contrast, the concept of systemic discrimination

> …is more problematic because it involves largely unintended or unconscious discrimination where, regardless of the personal views of the people involved, the outcome is that a significantly lower number of women and people of colour are hired than able-bodied white males. These outcomes are due to processes

> and practices in which discriminatory notions have become embedded. (Vladi, 2007, p. 299-300)

As the above definition suggests, identifying "systemic discrimination" can be particularly challenging as it often lacks the clear manifestation of intent of more overt discrimination. For this reason, critics in Vladi's report sometimes refer to it as a "hidden form of discrimination" as it can occur "as a result of seemingly neutral parameters, actions or procedures that at first do not seem to act as exclusionary criteria in a discriminatory sense and yet limit opportunities of select minority groups for reasons including, but not limited to, their race, ethnic background, sex, sexual orientation, or physical ability" (Vladi, 2007, p. 300).

Other studies have noted this challenge in understanding the contributory factors that shape barriers to credential recognition in Canada for all professions, and not just IMGs. Li (2001) references studies which have found that professional licensing bodies can have arbitrary standards for recognition. In other cases

> …those with foreign credentials often had to meet more stringent standards than those trained in Canada before professional certification was given; for example, in engineering, foreign-trained engineers were required to complete a longer period of satisfactory practice experience, in addition to fulfilling all examination requirements (Li, 2001, p. 25)

However, these barriers – often manifestations of systemic discrimination – are particularly challenging because this type of discrimination is "built into organizational structures and processes, and often involving informal activities and cultures" and thus "is by its nature difficult to identify" (Beck, Reitz and Weiner, 2002, p. 1). Given that – as Beck et al. notes – surveys have consistently found that the vast majority of the Canadian public express disapproval of racism and race-based discrimination, it is not surprising that where such discrimination exists in our society "it is likely to be hidden" (Beck, Reitz and Weiner, 2002, p. 2).

In Tetchena Bellange's (2010) documentary film, *Doctors Without Residency*, he explored the experiences of numerous qualified IMG physicians in Quebec who have been refused residency positions. He contends that many residency positions are going unfilled, not due to lack of skill or experience of IMG candidates but based on the systemic discrimination that exists in this selection process. This film represented a particularly useful source to deepen our understanding about the underutilization of IMGs in Quebec's, and Canada's, medical system. In its presentation and in using stark visual interviews of leading figures of the Canadian medical establishment, Bellange (2010) also gave a voice to unreasonable defences of the indefensible and gave a better account of the situation. For example, the film interviews stake holders from a variety of positions to explore the complex issues related to IMGs integration in Canada. The film is a useful source because it allows IMGs to express their difficulties with the accreditation process from their perspective. In this way it demonstrates the real problems faced by IMGs instead of using statistics and theoretical discussions.

According to Bellange (2010) in Quebec in 2009, 94 hospital residencies were left vacant while 60% of foreign-trained doctors- who had passed all of the exams of Quebec's College des Medecins- were refused a residency (Bellange, 2010). In the film, Dr. Yves Robert, Secretary of Quebec's College des Medecins, explains this refusal of residency on the grounds that not all doctors are alike. Robert notes that, as an example, doctors from Africa would not be needed in Quebec as African diseases such as malaria do not exist in Quebec (Bellange, 2010). Fo Niemi, the Director of Quebec's Center for Research-Action on Race Relations, is subsequently interviewed for the film, and expresses astonishment at such a viewpoint:

> And I thought that illness was universal? Most of these doctors were trained in major universities. Even in Africa and other places these universities get technical support from countries in the West, so they're not from villages and clinics with no hot water....I think it's a rather disparaging generalization (Bellange, 2010)

Thus, it may be argued that what we are seeing in the astonishing disparity between the need of Canada for physicians, and the refusal of Canada's medical establishment to allow qualified IMGs to take unfilled residencies, is institutional or systemic discrimination based primarily upon race and culture of origin. Fo Niemi declares about this issue:

> The discrimination that concerns us most is systemic...unspoken rules which in their application create consequences, effects that result in the exclusion of members of minorities (Bellange, 2010)

It may be argued that this film illustrates the manifestation of systemic discrimination in the labour market. As one critic argues with reference to the Canadian context, barriers rooted in systemic discrimination

> …can include informal selection based on unnecessary qualifications (the requirement for Canadian experience, for example), informal recruitment systems...and selection committees consisting only of long-term employees (few of whom happen to be members of minority groups) (Beck, Reitz and Weiner, 2002, p. 4-5)

As has been noted, one of the challenges in addressing the paradox of the experience of IMGs in Canada – qualified medical professionals, needed by an aging Canadian population, are unable to find positions which go unfilled – is that it is difficult to point to any one policy or regulation and say that it is discriminatory. Further it must be emphasized that these IMGs who are blocked by an inability to obtain residencies are individuals who have been considered qualified to practice medicine – with regard to passing the required examinations as set by their respective regulatory bodies – but cannot obtain the Canadian-based experience necessary as a critical final step before practicing medicine in Canada.

In this context, one of the most surprising aspects of the scholarly literature on IMGs is the limited number of focused studies on how systemic discrimination impacts this group in terms of health care policy and the medical establishment (Moore and Rhodenbaugh, 2002; Balon, Mufti, and Riba, 1997, p. 19). For example, in the United States in the past decade there was only "one published qualitative study on IMGs and bias in the literature" (Woods, Harju, Rao, Koo and Kini, 2006). It seems, however, that this issue is gaining more scholarly attention in recent years. For example, in 2010 Desbiens and Vidaillet found that discrimination has played a role in the residency selection process for IMGs in the United States (Desbiens and Vidaillet, 2010).

Scholars have argued that one of the primary challenges in researching discrimination in this area of health care policy and implementation is that the nature of the system blocks clear analysis. As one study found:

> Part of the bias against IMGs by residency programs in the past may have been evaluative bias. It had been very difficult to ascertain whether IMGs were adequately trained or prepared for U.S. residency programs (Desbiens and Vidaillet, 2010, p. 3)

This "evaluative bias" can be seen in Canada, in the case cited above in Quebec where African physicians were evaluated by the Quebec's College des Medecins unqualified to practice in Quebec as African diseases and illnesses were nothing like those experienced by Quebecers (Bellange, 2010). However, less overt cases of this bias would admittedly be far more difficult to call out as discriminatory.

It is important to note that not all barriers put in place by Canada's federal and provincial governments that have blocked IMG settlement and integration are informed by systemic discrimination. For example, as noted above, the initial barriers put in place against IMGs in the 1990s – in response to the Barer/Stoddart (1992) report's recommendations – were

part of a large policy determination to restrict the supply of physicians in Canada in order to reduce health care costs. These barriers were paralleled by a decision to cut funding for enrolment for Canada's medical schools; a decision that clearly is not informed by discrimination.

In the years since, however, as noted above there has been a realization that this decision was flawed, and that Canada needs more physicians. Accordingly, it must be acknowledged that both the federal and provincial governments have generally advocated more IMGs settlement and practice in Canada. Indeed, as noted above, in both Ontario and Canada as a whole, considerable government attention has been devoted to this issue.

The discretionary policy role of the federal government in addressing the underutilization is much more limited. This is due to the nature of Canadian federalism, which places responsibility for health and education in the domain of the provinces and territories. From this perspective, the role of the federal government is primarily to add funding and to ensure that country-wide standards of care are maintained (Bowmer, Banner and Buske, 2008). In this regard, the federal government has limited its role on IMGs to focusing on technical solutions- the creation of networking capabilities making the process of IMG evaluation more efficient.

It should be noted that federal actions in this area – in the form of the Foreign Credentials Referral Office and the Foreign Credential Recognition Program – are nonetheless critical and important initiatives in improving the credentials accreditation process for IMGs in Canada. As the Federal Government notes, while the provinces and territories have constitutional responsibility for foreign credential recognition – a responsibility that is generally delegated to regulatory bodies such as provincial Colleges of Physicians – there are a

number of these regulatory bodies governing IMG practice across Canada, each with distinct standards and accreditation procedures. Accordingly, the Federal government initiated the Foreign Credentials Referral Office and the Foreign Credential Recognition Program to provide a measure of national consistency by delivering assistance to both IMGs (and other professionals) and support to the provinces in efforts to "break down barriers to the recognition of foreign credentials" (Foreign Credentials Referral Office, 2011).

In terms of provincial initiatives in the area of recognition of IMG credentials, in general the provinces seem to have mirrored the Federal Government in retaining the same template that the Federal Government initiated, as per above. For example, one policy initiative of the Ontario provincial government to address the underutilization and lack of accreditation of IMGs was the launch of the Health Force Ontario Access Centre for Internationally Educated Health Professionals to provide individualized assessment services for IMGs with reference to their past experiences and particular needs. These services include: "referrals to the appropriate regulatory body; links to education, retraining and assessment programs; information about standards for professional qualifications, licensing and registration processes" (Broten, 2008, p. 15).

In this analysis, it is surprising that the Ontario provincial government has not initiated policies to address one of the central barriers to IMGs integration in Ontario: the problem of IMGs obtaining residency spaces as a qualifying stage before practice. The literature from the United States suggests that when bias and systemic discrimination against IMGs manifests itself in health care systems, it occurs more frequently at this stage where it is difficult to clearly define bias in evaluation.

This view is reinforced by the findings of the Quebec Human Rights and Youth Rights Commission in 2010, after a comprehensive investigation of Quebec's four medical schools, its College of Physicians, and its Ministry of Health and Social Services. The Commission found that IMGs have been discriminated against in the Quebec medical system primarily in the process of accessing residency positions. It found that IMGs have 6 to 7 times less chance of gaining a residency position, and that teaching hospitals leave 60 to 70 positions unfilled each year rather than fill them with IMGs who have passed all their medical qualifying exams (Quebec Human Rights and Youth Rights Commission, 2010).

In this analysis, while IMG experiences cited above suggest that something similar may be occurring in Ontario, Ontario has never subjected its health care system to the level of scrutiny on this issue that Quebec has for its system. While there does not seem to be proven evidence of systemic discrimination in the Ontario provincial policies on IMGs, it may be argued that the problem here is a "Sin of Omission" rather than a "Sin of Commission". That is, in the face of a growing body of evidence suggesting the existence of systemic discrimination in the residency selection process in other jurisdictions – both in the US and in Canada – the Ontario government has not put in place policy remedies to ensure that this discrimination cannot play a role in the Canadian health care system.

Chapter 5: Experiences of IMGs

While this paper has focused thus far upon the issue of IMGs in Canada from a "macro" perspective – for example, in terms of Canadian demographic trends and federal and provincial health care policy –we should not forget that we are dealing with real human beings who are impacted by these policies down to the family and individual psychological level. It may be argued that these perspectives are worthy of consideration given that IMGs will often make their critical decisions regarding continuing efforts to surmount barriers to their accreditation and practice on the basis of these levels. We need to know: (1) Who are these people, and (2) what are their experiences of Canadian health policies?

One of the most surprising – and significant – facts to emerge from the existing literature on the underutilization of IMGs is that Canadian governments have no clear idea how many IMGs are even in this country. According to the Association of International Physicians & Surgeons of Ontario there are actually "no accurate statistics on exactly how many licensed physicians from other countries have immigrated to Canada and how many have settled in Ontario" (AIPSO, 2002, p. 3). In other words, while the Government of Ontario and Ontario's medical establishment may say that they are taking steps to reduce the gap between the needs of Ontario for more doctors, and the low level of licensing of IMGs, the fact remains that even the Government of Ontario has no idea how many IMGs are living within the province.

This is due to the fact that official statistics only measure the "licensed" IMGs practicing in Ontario, and do not take account of the number of medical professionals who have settled as immigrants but who are underemployed or not working in their medical field. As AIPSO (2002) notes:

> Most of those who arrived during the 80s and 90s, when entry into the system was nearly impossible, have simply given up and left their hopes of continuing their medical careers behind (AIPSO, 2002, p. 3)

AIPSO (2002) estimates suggest that, as a rule of thumb, the number of IMGs who currently reside in Ontario, but who are not licensed, would be approximately four times the number who are currently recorded as licensed (p. 3).

This finding is supported by the research of Statistics Canada on the subject of accreditation in the Canadian medical profession. As we can see from Table 1 (Appendix C) – derived from Boyd and Schellenberg (2008), which was based upon 2007 Statistics Canada data – while there are wide discrepancies based upon global region of origin, there are also significant discrepancies based upon the time when the IMG first came to Canada. In sum, the more recent an IMG's arrival in Ontario or Canada, the lower the likelihood is that the IMG will be licensed to work in his or her medical field. As Table 1 indicates, for more recent IMG arrivals in Canada, it was less and less likely that they would ever practice in the medical field in a province where their skills were desperately in need.

5.1 The Complex Costs to IMGs from Barriers to Accreditation

Assessing the costs to IMGs from barriers to accreditation and resulting underutilization is complicated by the diverse complexity of these costs. The immediate financial costs of these barriers to IMGs are the easiest to calculate, as studies have found that IMGs in Ontario will spend 42% of their annual income in years prior to licensure on qualifying courses and examinations necessary for practice (Sharieff and Zakus, 2006, p. 4). When we consider that these IMGs are – in contrast to Canadian medical graduates – significantly more likely to (1) be married, (2) be female, and (3) have dependents including

children (Szafran, Crutcher, Rodney, Banner, Sandra, R, and Watanbe, M., 2005, p. 1246), we can easily understand the complex human costs associated with these years of financial costs.

While it is clear to observers ranging from the Ontario Government to Ontario's medical professional bodies that there need to be more IMGs licensed and practicing in Ontario, in fact the numbers of IMGs in practice have only gradually increased over time. Indeed, as noted above, the Association of International Physicians & Surgeons of Ontario notes that it is likely the number of IMGs in Ontario who are not practicing outnumber those practicing by about fourfold (AIPSO, 2002, p. 3). Indeed, when Statistics Canada attempted to get a sense of the scale of this problem, they found that while 90 percent of Canadian-born individuals who studied medicine went on to practice medicine in Canada, only 55 percent of foreign-born individuals who studied medicine were practicing in the profession (Boyd and Schellenberg, 2008). One of the most interesting aspects of this Statistics Canada report, as cited by Boyd and Schellengberg (2008), was the finding that of those foreign-born who studied medicine 33% were not even working in the health care field. This is a significant finding as it suggests that a huge proportion of IMGs in Canada are not simply being underemployed – for example, foreign-born physicians working as nurses – but are actually not being utilized in Canada's health care sector at all!

Given that, as has been noted above, Ontario is facing a clear and present need for skilled medical professionals – a disproportion between demand and supply that is so vast it is likely to impose significant economic costs upon the province for the foreseeable future – the fact that such a vast number of foreign-born medical professionals are not even working in the medical field in Ontario is nothing less than shocking. To understand the factors contributing to this remarkable number – and, by extension, to the growing costs Ontario is projected to

face in the years to come due to the underutilization of IMGs – it is necessary to consider the economic and monetary costs of this underutilization to the IMGs themselves.

Licensing Costs

In order to practice in Ontario, IMGs must pass a number of licensing requirements to attain accreditation to practice in the province. These requirements are very costly, and require sizable cash investments by IMGs with no guarantee that the IMG will be licensed, with the costs of the accreditation process being non-refundable. Given that many of these IMGs migrate and settle in Ontario with their families, it is understandable that these costs would make them question whether they should even pursue a career in the field in which they were trained in their original country. In this analysis, we can interpret the information of Table 2 (Appendix D) with regard to the high number (33%) of IMGs in Canada not even working in the medical field as reflecting a rational choice – given the sizable financial costs of licensing – to give up on a career in medicine and work in a field where they can support their families. As the 2006 study concludes with respect to IMGs in Ontario "limited financial resources in relation to the current [licensing] process appear to negatively impact their pursuit for practice license in Ontario" (Sharieff and Zakus, 2006, p. 4). In this context, it may be argued that any assessment of the costs to IMGs of their underutilization in Ontario needs to consider the complex nature of these costs and incorporate factors such as gender, age, and the time of migration and settlement in Canada.

Costs in a Family and Gender Context

In general, IMGs are older than their Canadian-born counterparts, much more likely to be married, female and with dependent children (Szafran, Crutcher, Banner, Sandra and Watanbe, 2005, p. 1242). These individuals almost invariably enjoyed high status in their

countries of origin, and they have often had to overcome a range of barriers (for example, female doctors in countries with a high degree of gender bias) in order to attain their medical certification in their country of origin. Thus, in general, IMGs in Canada are not a group that would let something like unfamiliarity with English (or French) block them from achieving their career goals (Szafran, Crutcher, Banner, Sandra and Watanbe, 2005, p. 1242-1243).

However, this demographic model of IMGs in Canada reveals something of the barriers and costs faced by this group. Consider, for example, the issue of gender. Studies have long noted the impact of the increasing feminization of the physician workforce in Canada upon changing work practices in the medical profession. Female physicians work less in their practices than male physicians, and bill significantly less, given that they have to bear responsibilities for family and children that male counterparts often do not (Crutcher and Dauphinee, 2004, p. 44-45). While this is clearly inequitable and unfair it is also, quite simply, the reality facing female professionals in the medical field (and, doubtless, in numerous others).

Among the population of IMGs in Ontario and Canada, the percentage who are female is significantly larger than that among the population of Canadian-born medical graduates (approximately 63% of IMGs being female to around 50% of Canadian-born). Moreover, as these women tend to be older than their Canadian-born counterparts, they also tend to have immigrated to Canada with children. While these IMGs may have large ethnic communities in major Canadian metropolises, they usually lack extended family and friend networks to help with child care and family responsibilities – to say nothing of academic responsibilities - that many of their Canadian-born counterparts have (Bates and Andrew, 2001, p. 45). Thus, if we reflect upon the issue of costs to IMGs from integration only in terms of gender, we can

understand why simply assessing the costs to these IMGs from their underutilization solely in terms of the costs of licensing courses and exams would result in numbers that radically underestimate the real financial costs that they face.

Interestingly, the medical profession in Canada is beginning to recognize the real and significant costs these female IMGs experience that go far and beyond simply the costs of exams and books. Studies have noted, for example, that female IMGs seem to display much higher levels of stress and physical exhaustion than their Canadian-born counterparts. These are usually attributed to the higher levels of family and financial responsibilities they bear. Continuing, Joanna Bates and Rodney Andrew (2001) argue in their paper, that this is a complex matrix of issues related to integration including a continual need to feel they have to "prove themselves" – given the feeling that they are under particular scrutiny as female physicians – and both professional and cultural taboos against admission of stress. Their study observed that:

> ...there is often the sense that they must prove themselves. These residents' anxiety and depression can be interpreted as lack of knowledge, diffidence about the program, or arrogance. Admission of anxiety, stress, or depression may be culturally taboo in IMG's home culture (Bates and Andrew, 2001, p. 45)

Thus, it may be argued that female IMGs in Ontario today are under a series of double-binds: they must work the "double-shift" that many Canadian women face, with responsibility at work/school on top of responsibility for child care and the home; they must support their families on their income, while also paying for their own licensing courses/exams; they are understandably reluctant to show signs of stress and exhaustion, which could be interpreted negatively by their academic superiors/evaluators and/or other members of their cultural group.

With respect to gender balance, it must be acknowledged that many of these same factors that negatively impact female IMGs also impact their male counterparts though in

different ways. Studies have found that male IMGs that have historical origins from some non Canadian patriarchal cultures, where a particularly high value is placed on the expectation of a husband supporting his wife and family , sometimes experience depression when faced with barriers to practising and supporting their families in Canada (Violato, Watt and Lake, 2006, p. 39-40).

Psychological Costs

In assessing the costs to IMGs associated with their settlement and attempts to integrate into the Canadian medical system and Canadian society in general, it is critically important that we do not ignore the very real psychological costs. From a human capital perspective, studies of even those IMGs who have successfully integrated into the Canadian medical system have found that their experiences have significant psychological costs for this population that can be correlated to diminishing their capacity to contribute to the host society.

Shortly after initial settlement, the awareness grows among many IMGs of the limited financial prospects they will face in their immediate future as they try to earn a living, and often support their families, while attempting to qualify for practice in Canada (Wong and Lohfeld, 2007, p. 57). IMGs begin to feel a cultural disorientation that comes from feeling disconnected from Canadian society at large and, perhaps even more significant, from their profession as well (Wong and Lohfeld, 2007, p. 58). This feeling of disconnection may explain, in part, the notable reluctance of many IMGs to working in rural settings in Canada; settings quite a distance away from the large co-ethnic communities that tend to exist in Canada's multicultural metropolises (Violato, Watt and Lake, 2006, p. 6-7). Eventually, however, IMGs who have been able to practice in their field assert that they have developed the coping skills, and language and cultural resources, to enable their adaptation into Canadian

society (Wong and Lohfeld, 2007, p. 58). It must be understood that while these stages may sound bleak, this is what surveys indicate to be the psychological costs to IMGs in the most ideal circumstances; that is, successful integration into the Canadian medical system. In many cases, the experiences – and the psychological costs – for IMGs are much worse. However, it is important to recognize that IMGs are not a homogeneous population.

One of the most recent and detailed studies of IMGs in Canada – "A Longitudinal Cross-Sequential Study of the Professional Integration of International Medical Graduates from Application to Licensure" by Violato, Watt and Lake (2011) – emphasizes that the IMG population in Canada today is not only highly diverse, but their experiences do not all necessarily fall neatly into the sequential process outlined above (Violato, Watt and Lake, 2011, p. 6-7). This detailed, multi-year survey incorporating some 708 interviews to date reveals that while IMGs in Canada are an extraordinarily diverse population:

> The social and emotional experiences of IMGs are often rather negative. The negative emotions experienced by IMGs and documented in the research literature include frustration, embarrassment and fear. Despite overcoming major obstacles, it is not generally recognized that IMGs bring unique expertise to the practice of medicine in Canada (Violato, Watt and Lake, 2011, p. 1)

One of the aspects of the study by Violato, Watt and Lake (2011) is that this detailed, multi-year survey calls attention to how issues such as gender and family relations shape the psychological impact of years of waiting for licensure in Canada. For example, almost two-thirds (61.3%) of the participants in Violato, Watt and Lake (2011) were female, of whom 91.2% were married and 78.3% have children. Given that these women, while writing qualifying exams and applying for residency, must also somehow make money to support their children and care for these children, we can gain some understanding of the acute psychological "weight" of the accreditation process on these individuals. When we consider

that almost half of the IMGs surveyed believe that the accreditation process will take 4 or more years – in addition to the years they have already spent being educated in their country of origin – we may understand the feelings of anxiety many of these IMGs express (Violato, Watt and Lake, 2011, p. 2).

If we focus more closely on the individual experiences of IMGs in Canada we can see how – in their stories of their experiences and struggles towards integration – an interplay of identities (as medical professionals, and as members of distinct cultural groups in multicultural Canada) seems to be at work.

Consider, for example, Violato, Watt and Lake's (2011) discussion of the contrasting experiences of two IMGs in Canada – one a female physician from China, and the other a male physician from Iran – who arrived in Canada in the mid-to-late 1990s. Both IMGs note that there was little to no supports or organizations to assist them upon their arrival and that – as has been noted above – there were significant institutional and policy barriers in place to block them from qualifying to practice. As the Chinese physician observed:

> When she got here she wrote to the MCC to inquire about training positions for foreign doctors and was told there were none even if you passed the examination. She feels that the system was more closed then, and it is a bit more open now (Violato, Watt and Lake, 2011, p. 38)

It should be noted that other sources confirm this physician's description about the broad institutional resistance to IMGs being licensed. Indeed, in Quebec in 2007 the provincial government and Minister of Health sharply criticized the professional body regulating licensing IMGs for not allowing qualified IMGs to occupy residency positions that have long been open with no candidate to fill them (Fidelman, 2007).

Given their awareness of these obstacles, neither IMG attempted to get their license for some time after their arrival. Instead, the Iranian physician took several "survival jobs" to

support his family while his wife began a PhD program. Both candidates experienced what might be termed a “crisis of identity” as each felt denied from their professional practice, while at a loss at coping in Canadian society. The term “crisis of identity” is useful as it captures the sense of dislocation experienced by many IMGs in the course of their settlement and adjustment process in Canada. IMGs are no different from most of us in that they incorporate their work and professional purpose into their own identity. However, when these individuals – who have often enjoyed high status in their country of origin due to their education and medical practice – encounter repeated barriers in their licensure process in Canada, the psychological impact can be acute.

These IMGs’ sense of their personal identity as medical professionals is undermined by the licensing process, at the same time as they feel the pressure to integrate socially into Canadian society that may, in many ways, be alien to their culture and values. Their personal, professional, and cultural identities can all be in flux and even, in some cases, crisis. This was acute in the case of the Iranian IMG noted above, as he feels not only the pressure of professional integration, but also alienation from Canada and even his own son who is far more acclimatized and integrated into Canadian society than is his father (Violato, Watt and Lake, 2011, p. 39). In such cases, IMGs can question who they are and their purpose and social roles; a process that can have profound psychological impact.

In the case of the Chinese IMG noted above, this manifested as depression when she was unable to obtain a residency position. The impact was even more acute for the Iranian IMG:

> He felt he could not handle things anymore and would spend days when he could not stop crying. He tried to hide his symptoms from his wife and son but his wife realized what was going on. He ended up having to take a couple of

> months off of work to deal with his depression (Violato, Watt and Lake, 2011, p. 40)

The above example is illustrative of the compounding nature of the sometimes negative psychological impact of the licensure process upon IMGs. The Iranian IMG felt a sense of failure at being unable to get through the licensing process, which resulted in depression, that caused him to be unable to work and thus unable to support his family for a period; a period when the reliance for economic support for the family fell on his wife who was also doing her PhD (Violato, Watt and Lake, 2011, p. 40).

These narratives are suggestive of something of the "real" costs of integration for IMGs in Canada; costs that far transcend a few hundred dollars for books, or even thousands of dollars for licensing exams. The complex cultural dynamics and issues that are often associated with immigrant settlement and integration in Canada are, in the case of many IMGs, aggravated in diverse ways by their identities as highly ambitious individuals who enjoyed high status as professional medical practitioners in their countries of origins. The psychological impact upon these individuals of their being challenged to even provide for their families' basic subsistence in Canada – and the array of complexly gendered stresses and anxieties that come with these family responsibilities for both female and male IMGs – are increasingly being recognized by the Canadian medical community (Bates and Andrew, 2001, p. 46). In this analysis, it is clear that the "costs" to IMGs of their underutilization in Ontario and Canada are enormous, and of clear significance for not only this population but for the provincial medical community and our society as a whole.

Conclusion & Future Direction

This literature review has demonstrated that the underutilization of IMGs in Ontario and Canada is a problem that has its roots in flawed health policy implementation of the recent past; in particular, the decision by Canada's health ministers – in a flawed response to the findings of the Barer-Stoddart (1992) discussion paper in the early 1990s - to make an across-the-board cut of 10% in enrolment in Canada's medical schools. While in the short term this cut was accompanied by a sharp reduction in the number of IMGs accredited in Canada throughout the 1990s, in the long term this decision resulted in a physician shortage that highlighted Canada's barriers to IMG accreditation in stark relief.

As this paper has demonstrated, in the two decades since the Barer-Stoddart (1992) report, the value of IMGs as a solution to Canada's lack of trained medical professionals to meet the needs of its growing and aging population has been publicly acknowledged by not only the Federal Government, but also Canada's Provincial Governments and their respective medical regulatory bodies. Yet while all parties seem to recognize the need for increasing IMG accreditation and entry into medical practice in Canada, many commentators note the surprising paradox that institutional barriers continue to be in place to IMGs in the licensing and, in particular, in the residency stages of the qualification process.

This paper has reviewed the existing literature on the impacts of this situation on the emotional, financial and professional lives of IMGs. In general, it is clear that these impacts are highly negative. In this context, we can understand the reasons why the choice of many of them to forego a career in medicine is both logical and understandable. The barriers to eventual practice are such that many IMGs in Ontario and Canada today have made a rational decision not to work in their specific medical field as they need to support themselves and their families

and cannot spend the years necessary to go through the stages of qualifying exams and interviews for residency positions.

This paper has also focused particular attention on the existing literature on the underutilization of IMGs in Canada with particular regard to the role of cultural factors that shape the barriers to IMG accreditation and licensing for practice.

While it must be emphasized that this literature review is limited in its scope, there are indications that systemic discrimination may be playing a role in the labour-market exclusion of IMGs in the Canadian context. The challenge in introducing systemic discrimination as a tool for analysis is that, this paper have noted, its manifestation can by definition be difficult to identify. Barriers and criteria for licensing and hiring that may seem neutral and bureaucratically institutional upon first glance are revealed as systemically discriminatory only through extensive critical analysis. While such analysis is beyond the scope of this paper, nonetheless the existing literature on this topic is suggestive of the view that the barriers responsible for IMG underutilization in Canada today have been shaped by institutional forces that may reflect embedded discriminatory attitudes towards immigrants and those who do not reflect the values or cultural attributes of the leaders of the Canadian medical establishment.

As such, this literature review should be seen as a preliminary work. Although it has drawn together data and findings of some of the existing literature, there is a need for a more detailed critical analysis and study of the factors discussed and their influence on the issues of IMG underutilization and integration in Ontario. This paper brings to light the need for further research to explore in depth, using calculated qualitative and quantitative studies, the full impact that IMGs endure as a result of discrimination in their licensure process- both from a cultural basis and on a feminization basis. If it is to be done professionally and ethically,

longitudinal studies could be undertaken in order to obtain the statistics and data to follow the progression or regression of these factors. In turn, these statistics can be used to make better and more resonant recommendations on what policy changes need to be made to the medical system that are conducive and will promote better health and well being of all Canadians.

Gaps in Existing Literature

While this literature review is preliminary and exploratory in nature, it allows us to better perceive gaps in the literature that need to be filled through further study. In particular, this literature review enables us to better understand the clear need for in depth research in several areas. One of the most important of these is the need for more studies of race, ethnicity and gender issues relating to the experiences of IMGs in Canada.

It is clear that the body of literature on the experiences of IMGs in Canada is limited. As this literature review has revealed, the existing work on this subject is – perhaps not surprisingly – largely from the point of the view of the host society in terms of the needs of Canada for more IMGs, and what solutions can be implemented to improve the credential review and licensing processes. While it is understandable that this should be a focus of considerable attention, the degree to which the interests of the host society dominate the body of scholarly literature on this topic is remarkable.

This being said, it must be acknowledged that researchers in this area face clear challenges in terms of the reluctance of many IMGs to come forward to voice their concerns and anxieties with regard to their experiences of the current system, and its costs upon themselves and their families. As we saw with the National Film Board of Canada documentary – *Doctors Without Residency* (2010) – the filmmakers discovered that not a single IMG in the province of Quebec, out of a population of thousands, was willing to go on

camera and publically detail their experiences of systemic discrimination that they would frequently detail to the filmmakers in private. Given the barriers that IMGs face, and the often highly subjective discretionary authority of those hospitals with residency openings, this reluctance is understandable. However, it nonetheless presents significant challenges to future detailed research with regard to the experiences of IMGs in Canada.

Furthermore my study highlights some reasons why further research in this area is critically important. Consider, for example, the gender dimension with regard to the experiences of IMGs in Canada. As we have seen, in contrast to the population of Canadian medical graduates, IMGs in Canada are more likely to be (1) female, (2) married, and (3) have dependents, including children. While about 50% of Canadian medical graduates are female, some 63% of IMGs are female (Szafran, Crutcher, Banner, Sandra, and Watanbe, 2005, p. 1246). Female IMGs also tend to be older on average than their Canadian-born counterparts, and the fact that they are immigrants significantly complicates their experiences. For example, while Canadian-born female medical graduates are likely to have support networks in Canada to enable them to better cope with the "double shift" that women in the work force tend to experience – that is, working in the paid work force, and then returning home to do the bulk of the unpaid domestic labour in the home – female IMGs in Canada tend to lack these extended family networks to help with child care and family responsibilities. The absence of an extended family support network for female IMGs is complemented by the absence of a professional support network as well; a clear advantage enjoyed by Canadian-born IMGs who have their Canadian medical school faculty and cohort/peers to draw upon for professional support. Perhaps not surprisingly, the existing research on this population reveals that they seem to

display significantly higher levels of stress and physical exhaustion than do their Canadian-born counterpart (Bates and Andrew, 2001, p. 45).

In this context, one of the most surprising discoveries in the course of this literature review is how the gender dimension of IMG's experiences – and, in particular, the convergence of gender-specific stressors together with those typically associated with immigrant experiences (e.g. cultural isolation in the host society due to language barriers, lack of support network) – has not been addressed in the institutional remedies for the problem of the underutilization of IMGs in Canada.

If we consider, for example, the 2004 report of the Canadian Task Force on Licensure of International Medical Graduates – whose recommendations were largely accepted by the ministers of health of Canada's provinces and territories, along with the federal government, none of the recommendations or the subsequent policy initiatives specifically address the specific problems that critically determine the underutilization of female IMGs in Canada.

It may be argued that this lack of institutional and governmental policy initiatives and recommendations specifically focusing on the concerns of female IMGs reflects the general absence of scholarly research on this population and their experiences. If this is the case, then there is a clear and present need for more research on this particular group to address such research questions as:

(1) Is there a gender dimension to the systemic discrimination experienced by IMGs in the Canadian health care system?

(2) In what way do ethnic/racial based biases and barriers complement gender-based barriers in this regard? For example, are female IMGs of one ethnic group

more likely to experience barriers in the licensing and residency-interview process than female IMGs of another ethnic group?

(3) How many female IMGs simply give up, and accept underemployment?

(4) What recommendations do female IMGs have in terms of specific supports and policy initiatives that might both enable a smoother qualification and licensing process, as well as enable them to better balance family and professional demands.

While one cannot predict the results of these studies, the outlines of this future research into the experiences of female IMGs appear clear. It is likely, for example, that members of this population will reveal the existence of both gender-based barriers in the licensing process for IMGs, as well as gender-specific stressors. Results in this area that will be particularly interesting are those that focus on the intersection of racial/ethnic and gender discrimination. These results would likely have relevance beyond the medical field as it would allow a better understanding of the complex dynamics of gender and race/ethnic based systemic discrimination in Canada.

Finally, as these results will likely have clear policy implications for provincial and federal ministries of health, the ultimate aims of research in this area is to gain greater institutional attention on the needs of this important segment of the IMG population and of the Canadian health care delivery system as a whole. Given the fact that female IMGs actually represent the majority of the IMG population, and what research has been done on them indicate that they experience significantly higher levels of stress than their Canadian-born counterparts, it is obvious and logical that there should be specific policy initiatives to enable

this group to contribute to the Canadian health system to their optimum level of their capabilities.

The most striking gap in the existing literature is, however, with respect to the issue of systemic discrimination itself. Given the size of this population, and the critical importance of its successful integration into Canadian society for the continued health and maintenance of the Canadian medical system, it is surprising to note the limited number of focused studies on how IMG are impacted by system discrimination, and the implications of this for health care policy in general (Moore and Rhodenbaugh, 2002; Balon, Mufti and Riba, 1997, p. 19). For example, it is nothingless than remarkable to discover that there has been only one qualitative study on IMGs and systemic discrimination conducted in the entire United States over the past decade. What little work has been done, however, indicates that systemic discrimination does play a role in the residency selection process – in the form of "evaluative bias" - for IMGs (Desbiens and Vidaillet, 2010). In the research that has been done on this topic, scholars argue that one reason for the lack of an extensive body of literature on IMGs and systemic discrimination is the difficulty of definitively measuring "evaluative bias" when the residency program hiring system is itself notably subjective and actually enables such lack of precise guidelines and determinations (Desbiens and Vidaillet, 2010, p. 3).

This explanation aside, it is clear that more research needs to be done on the topic of systemic discrimination and IMGs in Canada. Focused attention should be on such research questions as:

(1) Are there provincial differences in the levels of systemic barriers to IMG licensing and hiring? If so, why?

(2) To what degree are these biases due to race, ethnicity skin color etc, and to what degree are these biases part of the medical/health care culture?

(3) What remedies can policymakers institute to address these barriers to IMG licensing and hiring?

It was noted above that one of the recommendations of the Canadian Task Force on Licensure of International Medical Graduates was the development of an interactive, web-based learning tool that gives IMGs information on the cultural and communication standards expected for medical practice in Canada. While this was an admirable technical solution to support IMG integration into the Canadian health care system and Canadian society, one of the aims of further research on systemic discrimination and the underutilization of IMGs in Canada should be on what policy initiatives can enable Canadian health care institutions to be more accommodating to the concerns and needs of IMGs.

Longitudinal Studies

Further research into the experiences of IMGs in Canada with respect to issues such as systemic discrimination, as well as the costs of this group's underutilization at the personal, financial and psychological levels, could take the form of longitudinal studies. These are studies of individuals and population groups, conducted over an extended span of time, that allow the study of changes in the study group over time. With regard to IMGs in Canada, longitudinal studies would have clear benefits in that it would allow researchers to more clear assess the impact of the range of policy initiatives launched by government to address the underutilization of members of this group.

In this context, one of the clear and most surprising gaps in the scholarly literature is the absence of longitudinal studies with regard to this group. After all, given the resources and

investments of federal and provincial governments to meet the needs of these individuals – or, to be more precise, the needs of Canadian society for the skills and experience of IMGs in Canada – it is somewhat surprising that there have not been more studies to determine the effects of these initiatives over time.

It may be argued that the most interesting results from such studies are those that we would be unlikely to have anticipated. For example, one of the few longitudinal studies of IMGs in Canada – Violate, Watt and Lake (2011) – revealed not only the extraordinary diversity of the IMG population (an expected result) but also the important roles of gender and family concerns in shaping IMGs response to the years of waiting for their licensing approval and residency training. While longitudinal studies are both costly and complex, it is clear that their results will considerably enhance our understanding of this group and their needs.

Thinking Forward – The Need for Dimensional Convergence

In reviewing the findings of this exploratory literature review on the experiences and underutilization of IMGs in Canada, it is clear that systemic discrimination is a reality of life for members of this group. While admittedly there has been little scholarly attention to this topic, what research there is supports the view that systemic discrimination plays an important role in determining, and limiting, the licensing and employment prospects of members of this group in Canada.

My goal in this present research project has not been to break new scholarly ground with regard to IMGs and systemic discrimination but, instead, to review and delineate with greater clarity the outlines of the "evaluative biases" that block the licensing and residency hiring of IMGs in Canada today. Indeed, it may be argued that there is a clear and present need for more exploratory studies of systemic discrimination and IMGs in Canada – akin to the

present study, only more detailed, with more direct research (and possibly qualitative surveys/interviews with IMGs) – to enable our greater understanding of the complexities of systemic barriers in relation to this population group.

Appendix A

Fair Access to Regulated Professions Act, 2006 (abbreviated)

PART I
INTERPRETATION AND APPLICATION

Purpose of Act

The purpose of this Act is to help ensure that regulated professions and individuals applying for registration by regulated professions are governed by registration practices that are transparent, objective, impartial and fair.

PART II
FAIR REGISTRATION PRACTICES CODE: GENERAL DUTY

General duty

A regulated profession has a duty to provide registration practices that are transparent, objective, impartial and fair.

PART III
FAIR REGISTRATION PRACTICES CODE: SPECIFIC DUTIES

Information

A regulated profession shall provide information to individuals applying or intending to apply for registration by the regulated profession and, without limiting the generality of the foregoing, it shall provide,

(a) information about its registration practices;

(b) information about the amount of time that the registration process usually takes;

(c) objective requirements for registration by the regulated profession together with a statement of which requirements may be satisfied through alternatives that are acceptable to the regulated profession; and

(d) a fee scale related to registrations.

Timely decisions, responses and reasons

A regulated profession shall,

(a) ensure that it makes registration decisions within a reasonable time;

(b) provide written responses to applicants within a reasonable time; and

(c) provide written reasons to applicants within a reasonable time in respect of all registration decisions and internal review or appeal decisions.

Appendix B

Centre for the Evaluation of Health Professionals Educated Abroad (CEHPEA): (abbreviated)

Examinations conducted by CEPHEA in 2010/11
In total, 522 IMGs participated in examinations offered by CEHPEA from April 1, 2010 to March 31, 2011. CEHPEA conducted:

- 7 Clinical Exams (CE1) in the Family Medical Stream
- 1 Clinical Exam (NAC OSCE) in the Family Medicine Stream
- Specialty Written Exams (SWE) for Anesthesia, General Surgery, Internal Medicine, Obstetrics/ Gynecology and Orthopedic Surgery and Pediatrics
- Specialty Clinical Exams (CE2) Anesthesia, General Surgery, Internal Medicine, Obstetrics/ Gynecology and Orthopedic Surgery and Pediatrics
- Surgical Skills Exams for General Surgery Obstetrics/ Gynecology and Orthopedic Surgery

CEPHEA's General Comprehensive Clinical Examination (CE1) provided Program Directors of Ontario's Faculties of Medicine with important information to assist them in selecting candidates for residency. The CE1 was an Objective Structured Clinical Exam (OSCE) that tested clinical skills with emphases on communications, data collections, management and professional skills.

The NAC OSCE was formally launched on March 19, 2011. The NAC OSCE assesses the readiness of an IMG for entrance into a Canadian residency program. It is a national standardized examination that tests the knowledge, skills and attitudes essential for entrance into post-graduate training in Canada.

Appendix C

Chances of foreign-trained doctors who are recent immigrants working as a physician in Canada

Table 1:

	Predicted probability of being employed in a health occupation[1]		
	Medical doctors	Other health occupations	All other occupations
	percent (distribution across)		
Canadian-born	92	4	5
Immigrated before age 19	92	2	6
Immigrated at age 28 or older			
IMG Birthplace			
North America, Western Europe and Oceania	79	8	12
Eastern Europe	65	18	17
Caribbean, Central and South America	77	8	15
Africa	85	4	11
South Asia	87	3	10
South East Asia	62	21	17

East Asia	59	18	23
West Asia	63	6	31
Immigration period			
Arrived before 1980	95	1	4
Arrived from 1980 to 1985	86	8	6
Arrived from 1986 to 1990	76	7	17
Arrived from 1991 to 1996	70	11	20
1. Estimated chances out of 100 for persons aged 32 to 54 with highest level of schooling in medical fields of study when all other variables in the model are controlled for. Data source: Statistics Canada, 2001 Census of Population.			

Table source: Boyd and Schellenberg, 2008.

Appendix D

Just over half of internationally educated doctors worked as physicians in 2001

Table 2:

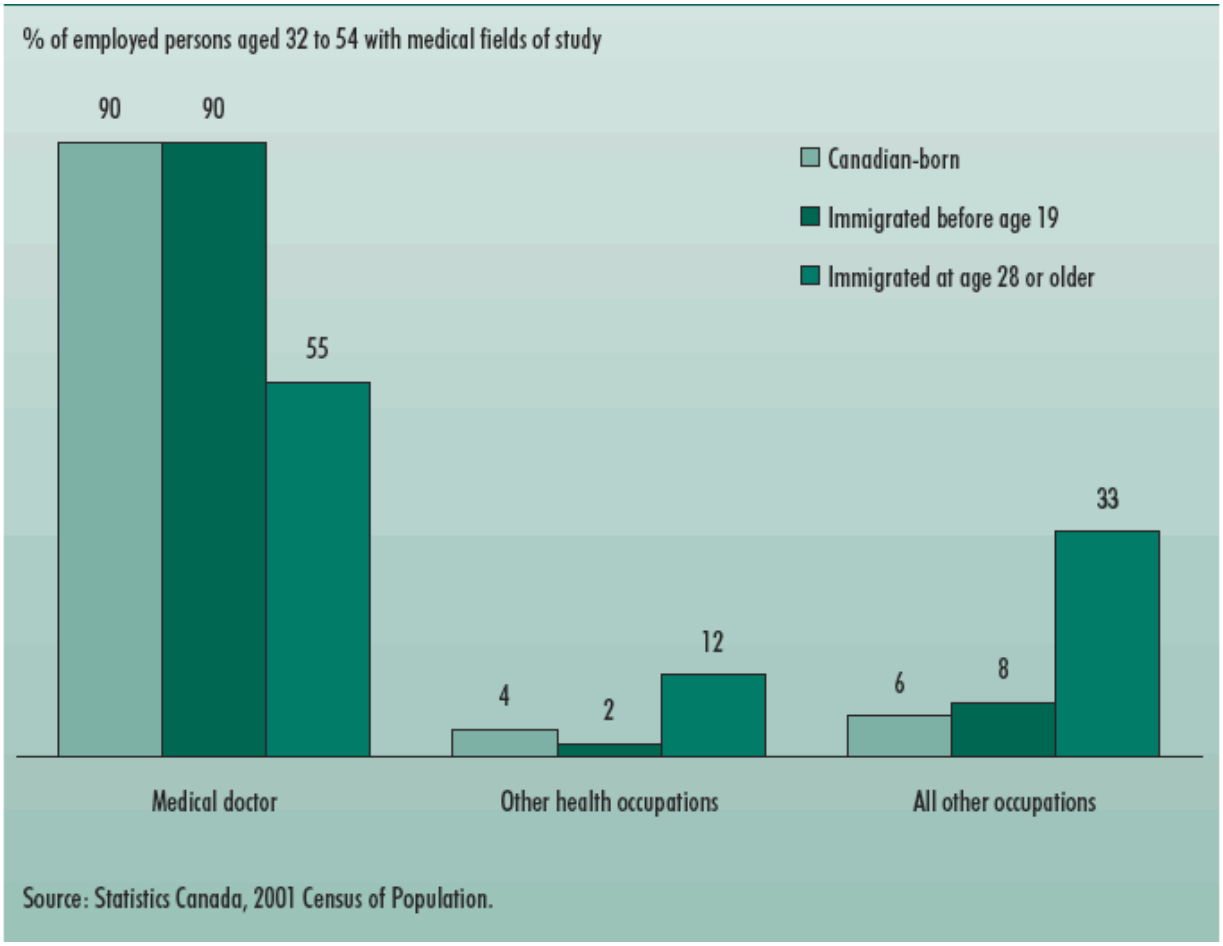

Table Source: Boyd and Schellenberg, 2008.

REFERENCES

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

Balon, R., Mufti R., Williams, M., Riba, M. (1997) *Possible Discrimination In Recruitment of Psychiatry Residents? American Journal of Psychiatry,* 154, pp. 1608-1609.

Barer, M. and Stoddart, G. (1992) Towards Integrated Medical Resource Policies for Canada. *Canadian Medical Association Journal*, 7(147).

Bates, J. and Andrew, R. (2001) Untangling the Roots of Some IMGs Poor Academic Performance. *Academic Medicine,* 76(1), pp. 43-46.

Beck, J. H., Reitz, J., Weiner, N. (2002) Addressing Systemic Racial Discrimination in Employment: The Health Canada Case and Implications of Legislative Change. *Canadian Public Policy*, 28(3), pp. 373-394.

Bellange, T. (2010) *Doctors Without Residency*. National Film Board of Canada, retrieved Jan. 3, 2013 from http://blog.nfb.ca/2010/04/07/doctors-without-residency/

Bowmer, M. I., Banner, S., Banner and Buske, L. (2008) Physician Self-Sufficiency. *International Medical Workforce Collaborative Conference.*

Boyd, M. and Schellenberg, G. (2008) Re-accreditation and the Occupations of Immigrant Doctors and Engineers. *Statistics Canada.*

Broten, L. (2008) *Report on Removing Barriers for International Medical Doctors.* Government of Ontario.

Canadavisa.com (2006, June 6) Ontario to introduce new Fair Access to Regulated Professions Act. Retrieved Jan. 3, 2013 from http://www.canadavisa.com/ontario-introduces-fair-access-to-regulated-professions-act.html.

Carstairs, S. and Keon, J. (2009*) Canada's Aging Population: Special Senate Committee on Aging Final Report.* Government of Canada.

CEHPEA (2007-2008) *Annual Report*. Centre for the Evaluation of Health Professionals Educated Abroad, retrieved Jan. 3, 2013 from http://www.cehpea.ca/about/annualReports.htm

CEHPEA (2011-2012*) Annual Report*. Centre for the Evaluation of Health Professionals Educated Abroad. retrieved Jan 3. 2013 from http://www.cehpea.ca/about/annualReports.htm

Chan, B. (2003) Physician Workforce Planning: What Have We Learned?: Lessons for Planning Medical School Capacity and IMG Policies. The Canadian Perspective. *International Medical Workforce Conference*.

Cornwall, C. (nd) "Why is Canada Shutting Out Doctors?" *Readers Digest*, retrieved Jan. 3, 2013 from http://www.readersdigest.ca/health/healthy-living/why-canada-shutting-out-doctors.

Crutcher, R. and Dauphinee, D. (2004, Feb.) *Report of the Canadian task force on licensure of international medical graduates*. Health Canada.

Desbiens, N. and Vidaillet, H. (2010) Discrimination against International Medical Graduates in the United States Residency Program Selection Process. *BMC Medical Education*, 10, pp. 5.

Esmail, N. (2011) *Canada's Physician Supply*. Vancouver: Fraser Forum.

Fair Access to Regulated Professions Act (2006) *Fair Access to Regulated Professions Act*, Government of Canada, Ottawa.

Fidelman, C. (2007, May 2) Medical board denies blocking foreign physicians. T*he Gazette.*

Fiscella, K., Roman-Diaz, M., Lue B., Botelho, F. (1997) `Being a foreigner, I may be punished if I make a small mistake': Assessing Transcultural Experiences in Caring for Patients. *Family Practice*. 14(2), pp. 112-116.

Fooks, C., Duvalko, K., Baranek, P., Lamonthe, L. and Rondeau, K. (2002) *Health Human Resource Planning in Canada: Commission on the Future of Health Care in Canada.* Government of Canada.

Foreign Credentials Review Office (2011) *Strengthening Canada's Economy – Government of Canada Progress Report 2011 on Foreign Credential Recognition*. Government of Canada, Retrieved Jan. 3, 2013 from http://www.credentials.gc.ca/fcro/progress-report2011.asp

Foster, L. (2008) Foreign Trained Doctors in Canada: Cultural Contingency and Cultural Democracy in the Medical Profession. *International Journal of Criminology and Sociological Theory*, 1(1), pp. 1-25.

Immigration and Policy Branch (2008) *Research and Statistics: Permanent Resident Landings 2008.* Government of Ontario.

Keung, N. (2010, Sept. 13) Foreign Doctors Petition for Ability to Practice While they Wait. *The Toronto Star*, retrieved Jan. 3, 2013 from http://www.thestar.com/news/investigations/immigration/article/860486--foreign-doctors-petition-for-ability-to-practice-while-they-wait

Kinchen, K., Cooper, L., Wang, N., Levine, D. and Powe, N. (2004) The Impact of Internatioanl Medical Graduate Status on Primary Care Physician's Choice of Specialists. *Med Care,* 42 (8), pp. 747-55.

Li, P. (2001) The Market Worth of Immigrants' Educational Credentials. *Canadian Public Policy-Analyse de politiques,* 27(1), pp. 23-38.

Mackrael, K. (2011, Nov. 1) Ottawa Urged to Help Expedite Licenses for Foreign-Trained Doctors. *Globe and Mail,* retrieved Jan. 3, 2013 from http://www.theglobeandmail.com/news/national/ottawa-urged-to-help-expedite-licences-for-foreign-trained-doctors/article2222079/

Ministry of Citizenship and Immigration (2006). *Fair Access to Regulated professions Act, 2006,* retrieved Jan. 3, 2013 from http://www.elaws.gov.on.ca/Download?dDocName=elaws_src_s06031_e

Moore, R. A., Rhodenbaugh, E.J (2002) "The Unkindest Cut of all: Are International Medical School Graduates Subjected to Discrimination by General Surgery Residency Programs?" *Current Surgery,* 59, pp. 228-236.

OECD – Organization for Economic Co-operation and Development (2010, Oct. 21.) *OECD Health Data* 2010.

Office of the Fairness Commissioner of Ontario. (2012) Mandate. *Office of the Fairness Commissioner of Ontario,* retrieved November 26, 2012 from http://www.fairnesscommissioner.ca/index_en.php?page=about/mandate

Ontario Ministry of Citizenship and Immigration (2010). *Ontario Immigration Key Trends Preliminary 2010 Information*. Government of Ontario, retrieved Jan 3. 2013 from http://www.ontarioimmigration.ca/en/tools/OI_RESEARCH_STATS.html

Ontario Ministry of Finance (2011, Spring) *Ontario Population Projections Update Spring 2011*. Government of Ontario, retrieved Jan. 3, 2013 from http://www.fin.gov.on.ca/en/economy/demographics/projections/#s2

Ontario Ministry of Health and Long-Term Care (nd.) *How to Become a Doctor in Ontario: Information for International Medical Graduates*. Government of Ontario, retrieved Jan. 3, 2013 from http://www.ontla.on.ca/library/repository/mon/16000/272404.pdf

Physicians Credentials Registry of Canada (2012) About PCRC. *Physicians Credentials Registry of Canada*, retrieved Jan. 3, 2013 from http://www.pcrc.org/en/about.shtml

Quebec Human Rights and Youth Rights Commission (2010, Nov.*) International Medical Graduates*, retrieved Jan. 3, 2013 from http://www.cashra.ca/past-featured/quebec-hr.html#six

Royal College of Physicians and Surgeons of Canada (2008) *Progress of the Task Force on Licensure of International Medical Graduates.* Health Canada, retrieved Jan. 3, 2013 from http:// rcpsc.medical.org/publicpolicy/force-poster-FINAL.ENG.pdf

Sharieff, W., and Zakus, D. (2006) Resource Utilization and Costs Borne by International Medical Graduates in their Pursuit for Practice License in Ontario, Canada. *Pakistan Journal of Medical Sciences*, 22(2), pp. 110-115.

Szafran, O., Crutcher, R., Banner, S. , R, and Watanbe, M. (2005) Canadian and Immigrant International Medical Graduates. *Canadian Family Physician*. 51, pp. 1242-1249.

Task Force on Physician Human Resource Strategy for Canada. *Physician Workforce in Canada: Literature Review and Gap Analysis.* Canadian Labour and Business Centre, 2003.

Violato, C., Watt, D. and Lake, D. (2011) *A Longitudinal Cross-Sequential Study of the Professional Integration of International Medical Graduates (IMG) from Application to Licensure: An Interim Report.* Calgary: University of Calgary Medical Education Research Unit, 2011.

Vladi, N. (2007) Race, Ethnicity and Workplace Diversity. *Organizational Behaviour in a Global Context,* Albert Mills (ed.), Peterborough, ON: Broadview Press, pp. 295-320.

Wong, A. and Lohfeld, L. (2007) Recertifying as a Doctor in Canada: InternationalMedical Graduates and the Journey from Entry to Adaptation, *Medical Education,* 42(1), pp. 53-60.

Woods, S., Harju, A., Rao, S., Koo, J. and Kini, D. (2006). Perceived Biases and Prejudices Experienced by International Medical Graduates in the US Post-Graduate Medical Education System. *Medical Education Online 2006,* 11(20), pp. 1-5.