RECOGNITION OF FOREIGN MEDICAL CREDENTIALS IN CANADA AND THE EU

A Thesis Submitted to the College of

Graduate Studies and Research

in Partial Fulfillment of the Requirements

for the Degree of Master of Arts

in the Department of Political Studies

University of Saskatchewan

Saskatoon

By

Petra Vychodilová

© Copyright Petra Vychodilová, August 2011. All rights reserved

PERMISSION TO USE

In presenting this thesis in partial fulfillment of the requirements for a Graduate degree from the University of Saskatchewan, I agree that the Libraries of this University may make it freely available for inspection. I further agree that permission for copying of this thesis in any manner, in whole or in part, for scholarly purposes may be granted by the professor or professors who supervised my thesis or, in their absence, by the Head of the Department or the Dean of the College in which my thesis work was done. It is understood that any copying or publication or use of this thesis or parts thereof for financial gain shall not be allowed without my written permission. It is also understood that due recognition shall be given to me and to the University of Saskatchewan in any scholarly use which may be made of any material in my thesis.

Requests for permission to copy or to make other uses of materials in this thesis/dissertation in whole or part should be addressed to:

Head of the Department of Political Studies
University of Saskatchewan
Saskatoon, Saskatchewan S7N 5A5
Canada

OR

Dean
College of Graduate Studies and Research
University of Saskatchewan
107 Administration Place
Saskatoon, Saskatchewan S7N 5A2
Canada

Abstract

The thesis presents research on recognition of physician credentials both in Canada and the European Union (EU). The research is concerned with three issues: licensure of international medical graduates (IMGs) in Canada, physicians´ mobility across Canadian jurisdictions, and physicians´ mobility within the EU. The main objective is to discover shortcomings in the Canadian system of qualification recognition and find out whether the EU experience has anything to offer to Canada´s labour mobility system. To achieve this aim, both interviews with representatives of Canadian medical organizations and web-based research were conducted.

From the obtained information three distinct conclusions became obvious: (1) the barriers IMGs experience when they pursue a medical licence in Canada are not caused by purposeful discrimination or unfair treatment by regulatory bodies; rather, they are a result of the absence of appropriate tools for assessment of IMGs´ credentials; (2) the revised Agreement on Internal Trade (AIT) did not eliminate inter-provincial barriers to mobility of physicians as expected; nevertheless, it led to a far more comprehensive approach—development of a national licensure standard; (3) although the EU took a different approach to accomplishing full labour mobility of physicians than Canada, the result turned out to be very similar—automatic recognition of physicians´ qualifications based on minimum education and training requirements. The EU has been on this path for almost half a century now, therefore, Canada should examine the EU experience and develop mechanisms that proved to facilitate the process of automatic recognition in the EU.

Acknowledgment

This research project would not have been possible without the support of many people. First and foremost, I would like to express profound gratitude to my thesis supervisor, Professor Hans Michelmann, who accepted me as his Master student without any hesitation. Thereafter, he offered me so much advice, patiently supervising me, and guiding me in the right direction throughout the whole research work. His professionalism and invaluable experience enabled me to complete my work successfully.

Special thanks are also given to Prof. Roy Romanow, a member of my committee, for the assistance he provided to me with contacting Dr. Greg Marchildon, Executive Director of the Commission on the Future of Health Care in Canada, and Prof. Steven Lewis, Canadian health policy consultant. I am also thankful to Prof. Don Story, the second member of my committee, who kindly agreed to read my thesis and comment on it.

I would like to express my appreciation to the three Canadian health care organizations and their representatives who have offered me their time when I was collecting necessary data for my research. I am immensely grateful to Dr. Dennis Kendel, Registrar of the College of Physicians and Surgeons of Saskatchewan (CPSS), for his forthcoming approach toward the interview and for the comprehensive information about the CPSS he shared with me during our conversations. I would also like to express my thanks to Dr. Ian Bowmer, Executive Director of the Medical Council of Canada (MCC), and Dr. Martin Vogel, Executive Director of the Saskatchewan Medical Association (SMA), for their suggestions and answers to my questions.

My sincere thanks go to Dr. Penny Davis, Assistant Dean of Continuing Professional Learning at the University of Saskatchewan, and Dr. Gill White, an Associate Dean at the

University of Saskatchewan. Their responses provided me with insights into the current initiatives designed to facilitate IMGs' assessment and recognition of their credentials.

Finally, I am especially indebted to my loving parents, František Vychodil and Dagmar Vychodilová, for their care and support in all my pursuits. Moreover my sincere thanks go to a dear friend, Richard Lomotey, who has always encouraged me and prayed for me.

Věnování

Tato práce je věnována mým rodičům,
kteří ve mě vždy věřili a podporovali mne po celou
dobu studií.

Table of Contents

Chapter 1

Introduction

1. Problem Statement

Canada is facing the largest wave of immigrant labour it has ever seen. As Canada´s population is aging and, as a result, its labour force is shrinking, immigration is seen as a partial solution to the labor shortage. Highly skilled immigrants with professional qualifications[1] earned outside Canada, however, often experience barriers to entry into the Canadian labour force. For decades, the Canadian federal government has enacted and maintained policies to attract highly skilled immigrants to support the growth and competitiveness of the Canadian economy (Girard & Bauder, 2005, p. 1). However, even though the federal government in most cases recognizes professionals´ qualifications for entry purposes, the provincial and territorial governments[2], responsible for regulating the labour market, often do not recognize them for employment purposes (ACCA, 2001, p. 3). Consequently, highly skilled immigrants have often been unable to find a position appropriate to their qualifications (Bauder, 2003, p. 699); taxi drivers with Ph. D. degrees serve as an example.

For provincial governments, the key challenge has always lain with identifying effective initiatives to recruit and integrate immigrants into their labour markets (Schmidtke, 2006). Much of the blame has been attributed to the system of foreign qualification recognition[3], which comprise the "programs and services governments use to decide whether

[1] For a definition see Glossary.
[2] From now on the term provinces (provincial) will include territories (territorial) as well.
[3] See Glossary.

someone with a diploma or degree from another country is competent to practise in Canada" (Lenihan, 2010, p. 44). This system has been described as highly bureaucratic, slow, and unfair in its assessment. International medical graduates (IMGs)[4], particularly, have viewed themselves as victims of this system and, as a result, often question its legitimacy.

2. Aim and Scope

The aim of this research is to examine policies that regulate certification requirements[5] and occupational standards[6] for recruiting and integrating IMGs into medical practice in Canada. The primary focus is on policies adopted by the provincial governments and professional regulatory organizations as the main regulators in this area. The research also examines the system for recognizing medical credentials[7] adopted by the national governments and regulators in the European Union (EU). The foremost reason for this approach is not a comparison between the Canadian and European system of credential recognition but a determination whether the EU model can provide any suggestions to Canada´s labour mobility system.

3. Overview of the Study

In order to achieve this aim, the thesis is divided into six chapters. Chapter 2, following this introduction, has two main sections. The first section provides an overview of the historical context and current evolution of the supply of family physicians in Canada. It points to the absence of any standardized and/or systematic collection of data regarding family physician supply across the country, which ultimately leads to problems with efficient human resources planning. However, it argues that regardless of whether or not Canada experiences a family physician shortage, its integration policies should not discriminate

[4] See Glossary.
[5] See Glossary.
[6] See Glossary.
[7] See Glossary.

against IMGs. The second section of this chapter then draws on the conclusions of the first section and identifies research questions together with an appropriate methodology to pursue them.

Chapters 3, 4, and 5 constitute the actual body of the thesis. Chapter 3 examines the accreditation[8] process for IMGs in Canada and the different value of medical credentials acquired around the world. Furthermore, it explores the relationship between the main medical regulatory organization in Saskatchewan, the College of Physicians and Surgeons of Saskatchewan (CPSS), and the main lobby group for physicians in Saskatchewan, the Saskatchewan Medical Association (SMA), to find out whether the SMA has any influence on the CPSS with regard to the establishment of regulations for IMGs. Chapter 4 moves beyond the discussion of barriers IMGs experience when they pursue a medical licence[9] in Canada and proceeds to examine inter-jurisdictional barriers physicians experience if they move from one province to another and their medical licence is not recognized. The predominant focus is on the revised Labour Mobility Chapter of the Agreement on Internal Trade (AIT) and the potential it has to resolve the current barriers to mobility of physicians within Canada. Chapter 5 investigates the EU´s response to the demands for a unified labour market in the area of health. It reviews the EU´s primary and secondary legislation to find out how the EU reached a consensus on the automatic recognition of physicians´ qualifications. Lastly, Chapter 5 also considers whether the EU experience can serve as an example for Canada.

Finally, Chapter 6 summarizes and integrates the main arguments and research findings, and connects the main thesis chapters to present a more overarching conclusion.

[8] See Glossary.
[9] See Glossary.

Chapter 2

Background

1. Introduction

Canada's unmet health care needs and limited supply of family physicians have been long time concerns for many Canadians. Reactions of the public have caused many who work in the planning and organizational side of health care to further address this issue to regulatory bodies (CPSO, 2004). Although the extent of a physician supply shortage in Canada is disputable, there is little doubt that patients experience difficulties finding a family physician in many areas (Sullivan, 1999). A 2007 Decima Poll, for instance, found that five million Canadians do not have a family physician and half of them are unable to find one (Sullivan, 2008, p. 29). Making matters even worse, aging of physicians, the reduced workloads desired by young physicians, and the growing number of female physicians[10] all contribute to the need for more physicians (OHRC, 2007).

This chapter consists of two sections. The first section presents a historical overview of physician supply in Canada, and highlights the main factors and events which have contributed to the current supply of health care professionals in Canada. To narrow the scope of the thesis to a manageable level, the research focuses solely on family physicians with special emphasis on Saskatchewan. The second section of this chapter presents a research design, outlining three main research questions, and also the methodology used for answering these questions.

[10] Many female physicians face the challenge of finding an acceptable balance between career and family. Professional women in many families remain responsible for household and child-related duties. Consequently, a lot of female physicians are likely to alter their job responsibilities to benefit their families and children, with the most common adjustment being a reduction in hours worked (Verlander, 2004, p. 331 - 333).

2. Physician Supply

2.1. Physician Supply in Canada – The Historical Context

Following the Hall Commission of 1964[11] a substantial increase in medical school enrollment occurred. At that time, Canada imported more foreign-trained physicians than it educated (Tyrrell & Dauphinee, 1999, p. 2). Their number further increased after 1967 when the federal government introduced a new immigration system based on points, which according to Reg Whitaker[12] (2001) constituted a shift from a discriminatory system based on "colour" to a system based on education, skills, and financial resources (p. 9). Moreover, physicians were on a so-called "open list" of priority occupations, which encouraged them to come to Canada.

In 1975, the "preferred status" of health care professionals immigrating to Canada was removed (Dauphinee, 2003; Tyrrell & Dauphinee, 1999, p. 2), and physicians without pre-arranged employment were not allowed to enter the country (Audas & Ross & Vardy, 2004, p. 3). Furthermore, in 1991 Morris L. Barer's and Greg L. Stoddart published a report recommending reducing medical school enrolment by ten percent, reducing the number of provincially funded post-graduate residency-training positions by ten percent and reducing Canada's reliance on foreign-trained doctors[13] (Barer & Stoddart, 1991, p. 4 - 6). Accordingly, Canada slowly lessened its dependence on IMGs (Pong & Pitblado, 2005, p. 26 – 27).

While the supply of physicians rapidly decreased, Canada's population kept growing, thereby creating a demand for more physicians (Tyrrell & Dauphinee, 1999, p. 2; Statistics

[11] The Royal Commission on Health Services, known also as the Hall Commission, was established by Order in Council in 1961. Its purpose was to report upon the future needs for "health services for the people of Canada and the resources to provide such services, and to recommend such measures, consistent with the constitutional division of legislative powers in Canada" (Health Canada, 2004).

[12] Reg Whitaker is a Distinguished Research Professor Emeritus at York University and Adjunct Professor of Political Science at the University of Victoria.

[13] The Barer-Stoddard report stemmed from a view that managing the supply side of health care system would achieve more manageable costs. Reducing the number of doctors was seen as a solution to the rapid growth in physician payments (Decter, 1995, p. 35).

Canada, 2010). Consequently, in 2002 the federal government enacted a new *Immigration and Refugee Protection Act* removing any immigration restrictions on physicians (Audas et al., 2004, p. 3). That stimulated an increase of immigrant IMGs. However, since Barrer's and Stoddard's recommendations were not reversed, inconsistencies between Canada's welcoming immigration policies on one hand and weak integration practices[14] on the other emerged.

2.2. Physician Supply in Canada – Current Developments

Despite the current physician shortage in most remote and rural areas, many foreign-trained physicians have not been allowed to practise medicine in Canada. Although the physician-to-population ratio in Canada has slightly increased from 2.06 physicians per 1,000 residents in 2000 to 2.18 in 2009, with the OECD average of 3.1 physicians per 1,000 residents Canada still ranks 26th out of 28 developed nations (OECD, 2009). Despite the slightly increased number of physicians entering into medical practice, the situation worsened. Accordingly, the Canadian Medical Association (CMA) estimated that it would take at least 26,000 more physicians, at the moment, just to bring Canada up to the OECD average (Bacic, 2008; Sun, n.d.).

Those statistics, however, do not provide the whole picture. Today, the uneven distribution of physicians, leading to the need of a continuous recruitment of IMGs, is not only a matter of urban versus rural competition. Maldistribution of physicians is also typical for other regions, with a shortage in smaller communities distant from larger urban areas. As a result, Canada has often relied on foreign-trained physicians to meet its short-term physician needs in remote and rural areas (Health Canada, 2005). To portray the situation, in 2004, IMGs made up 26.9% of family physicians in rural areas compared to 22.6% in urban areas. Thus, rural areas with on average only 0.98 physicians per 1,000 residents have

[14] Weak integration practices resulted primarily from insufficient assessment mechanisms and ineffective licensing procedures.

benefited most from medical services provided by IMGs (Dauphinee, 2006). Yet, the paradox is that while IMGs do contribute to the filling of physician gaps in the most under-doctored areas of Canada, their potential to increasing the number of physicians is often overlooked.

To understand the conflict over the adequacy of today's physician supply in Canada, it is necessary to also present information indicating that the physician shortage may only be a perceived problem. Based on reports from the Canadian Institute for Health Information (CIHI), the number of physicians in Canada increased by 84.9% between 1978 and 2008 (2009, p. 23). Compared with the growth of the general population, statistics suggest that physicians are increasing in number at a faster rate. While between 2004 and 2008 the number of physicians increased by eight percent, there was only a 4.3 percent increase in the general population (p. 23). The Tommy Douglas Research Institute (2001) thus argued that a shortage of physicians is only one of many myths being circulated by the public to discredit Canada's health care system. It stated,

> Canada has more doctors than ever before. The number of physicians has grown over the last decade, at about the same rate as the population and the much publicized physician outflow is really a trickle. There are, of course, shortages of doctors in particular regions and specialties, and certain types of patients have particular difficulty accessing the current system. But localized mis-matches between needs and numbers available are an old familiar story. These problems do not reflect general shortages, and they have never been remedied by a general increase in supply (Rachlis, Evans, Lewis, & Barer, 2001, p. iii).

Also, the CMA has recently published an article, "Physician pool expands", which states that predictions about a massive wave of physician retirements have not been realized (Vogel, 2010, p. E138). On the contrary, the average age of family physicians in Canada increased by 5.6 years to 49.0 between 2004 and 2008. The CIHI also found that 69.2% of 1667 physicians who were between the age of 70 and 74 and working in 2004 continued

practising in 2008, as did 63% of the 643 physicians aged 75 – 79, and 47% of the 217 physicians aged 80 – 90. According to Lauren Vogel[15], the trend towards later retirement among physicians contributed to a "swelling of the physician ranks" (p. E138).

Furthermore, predictions about Canada's increasing dependence on IMGs have not been realized either. While IMGs constituted 30.8% of all physicians in Canada in 1978, that percentage decreased to 23.2% in 2008 and the number of Canadian medical graduates (CMGs) increased from 69.2% to 76.8% during the same interval (CIHI, 2009, p. 38).

2.3. Physician Supply in Saskatchewan

An important goal of every government is to balance the demand for and supply of physicians. Since Saskatchewan has often struggled with the supply of physicians, one of the priorities of its government has been to increase the supply of family physicians (Saskatchewan Ministry of Health, 2009). According to the CIHI report, the number of physicians grew by 8.6 percent[16] from 2004 to 2008 (versus eight percent nationally) (2009, p. 13). Looking solely at family physicians, their number grew by nine percent during that time (versus 8.4 percent nationally). Since the increase in number of physicians between 2004 and 2008 occurred at a greater rate than the growth of the population (8.6 percent versus 3.1 percent), the physician-to-population ratio expanded as well—from 154 to 162 physicians per 100,000 population (p. 13).

However, in spite of the recent steady growth in the number of physicians in Saskatchewan, Saskatchewan still ranks ninth among all jurisdictions in Canada in the number of physicians per population. One of the major challenges for Saskatchewan lies in

[15] Lauren Vogel is the current Reporter at the Canadian Medical Association Journal.

[16] While the CIHI stated that the physician increase between 2004 and 2008 was by 8.6% (2009, p. 13), the Saskatchewan Ministry of Health reported that the increase between 2004 and 2008 was rather by 12% (2009, p. 1). Consequently, both reports came to different conclusions in terms of number of physicians that were licensed to practise in Saskatchewan in 2008—1660 (CIHI, 2009, p. 13) versus 1860 (Saskatchewan Ministry of Health, 2009, p. 1). While the CIHI stated that semi-retired physicians, residents, and military physicians were excluded from the final analysis, the Saskatchewan Ministry of Health did not specify any criteria used for identifying "active physicians". Therefore, the differences in statistics may have very well been caused by various criteria applied for identifying "active physicians".

retaining its own University of Saskatchewan graduates. As the Saskatchewan Ministry of Health report (2009) pointed out, Saskatchewan retains "on average, 58% of these graduates, while other provinces retain 72%" (p. 1). This is one reason why the supply of physicians is low in Saskatchewan and why patients often experience difficulties with accessing services of family physicians and specialists.

Due to its large number of remote and rural areas and IMGs´ willingness to practise there, Saskatchewan also relies more heavily on foreign-trained doctors that any other province (Hutten-Czapski, 2001, p. 20 – 21). According to CIHI information (1987 – 2003), close to 55%[17] of all physicians practising in Saskatchewan are foreign-trained (Baerlocher, 2006). On the other hand, the number of IMGs in Saskatchewan has been continuously decreasing with 778 IMGs (517 family physicians) in 1996 compared to only 706 IMGs (437 family physicians) in 2008 (CIHI, 2009, p. 62; CIHI, 2001, p. 46). To conclude, unclear physician-supply statistics and reports, their different interpretation, and uncertainty about the "right" physician-to-population ratio make it very hard to assess where Canada, and Saskatchewan, stand with regard to physician shortages.

3. Conclusion

Although statistics on the supply of physicians in Canada do exist, there is no standardized and systematic collection of data across the country. As Roy Romanow[18] noted in his Report 2002, "looking at Canadian averages tells only part of the story [as] there are significant differences among provinces in the supply of family physicians and general practitioners" (p. 97). Moreover,

[17] The percentage of IMGs again varies depending on the report. However, in terms of the number of IMGs practising in Saskatchewan, both CIHI and Saskatchewan Ministry of Health agree that the percentage is between 43 – 50% (CIHI, 2009, p. 62; CIHI, 2008, p. 54; CIHI, 2007, p. 60; CIHI, 2006, p. 50; Saskatchewan Ministry of Health, 2009, p. 1).

[18] Roy Romanow served as Deputy Premier of Saskatchewan from 1971 to 1982. In 1979 he was appointed Saskatchewan's Minister of Intergovernmental Affairs, and from 1991 to 2001 served as a Premier of Saskatchewan. In 2001, Romanow was appointed to head the Royal Commission on the Future of Health Care in Canada. In 2002, he released the Romanow Report, which outlined suggestions to improve the health care system.

> While physician organizations (CMA 2002) and many communities point to serious problems in meeting the need for physicians, other studies suggest that there is far less consensus about whether or not we have a crisis in the supply of physicians (p. 97).

Results and conclusions of various studies often differ, and it is very difficult to assess whether the present growth of health care professionals will meet the future health care needs of Canadians (CIHI 2002b in Romanow, 2002, p. 108). Also, while some statistics and reports do include information about health care providers (such as their number, distribution, education, training, recruitment, nationality, gender etc.), only few of them specify the actual criteria applied for classifying physicians (i.e. who is considered to be an active physician).

Since no central agency or medical organization has much in the way of hard data about physician numbers, documenting the shortage of physicians is an enormous problem. According to Elizabeth Howell [19] (2008), although two physician organizations—the Canadian Institutes for Health Research and the CMA—have conducted research regarding physician shortages, but physician organizations take issue with their findings. For example, when the CMA requested human resources data from the College of Family Physicians of Canada (CFPC) and from all 47 specialty groups registered with the Royal College of Physicians and Surgeons (RCPS), only 27 groups responded (56%), and only 13 had conducted studies over the past decade. Furthermore, only six actually addressed the issue of physician shortages. Of the 21 groups that did not participate at all, four refused to comment, and 17 did not respond to repeated inquires. Evidently, some physician organizations are not willing to share their information. Lack of such information is, however, a great limitation

[19] Elizabeth Howell is currently a chairperson at Physicians Licensing Board, Utah Division of Occupational and Professional Licensing. She is also a Director at American Board of Addiction Medicine.

because governments rely on these data to determine how many medical school places or residencies to fund.

To conclude, even in today's information overload society, governments, regulatory organizations, and employers are still unable to determine the right physician-to-population ratio. Insufficient information about human resources, identifying areas of surplus and shortage of professionals, then inevitably leads to problems with efficient human resources planning requiring clear statistics for assessing the data. For the lack of statistical data, the thesis does not attempt to answer the question whether Canada does experience a shortage of physicians; however, it does argue with Jason Kenney[20] (2010) that regardless of what the "right" physician-to-population ratio is, not to allow doctors to enter into their field of profession after approving their immigration status is simply unethical.

4. Research Design

4.1. Methodology

Both qualitative and quantitative sources were used to inform the overall thesis. Quantitative data were drawn primarily from CIHI, CMA, and Organization for Economic Cooperation and Development (OECD) sources. Qualitative data comprised both primary and secondary sources. Primary sources included official government documents, documents of non-governmental organizations/associations, media reports, and interviews. Scholarly journal articles served as the main source of qualitative secondary information.

However, because there was very little secondary literature on the topic, some chapters of the thesis relied largely on interviews and other primary resources such as newspaper articles, letters, speeches, and government reports. As for the interviews, a snowball method was employed as a technique for sampling potential respondents. Interviews were semi-structured with open-ended questions. While most of the questions were designed and

[20] Jason Kenney is the Minister of Citizenship, Immigration and Multiculturalism in Canada.

phrased ahead of time, additional questions arose from the discussion during the interview, allowing the author to pursue unanticipated but important lines of inquiry. Among the main respondents were:

- Dr. Dennis Kendel, CPSS Registrar;
- Dr. Martin Vogel, Executive Director of the SMA;
- Dr. Ian Bowmer, Executive director of the Medical Council of Canada (MCC);
- Dr. Penny Davis, Assistant Dean of Continuing Professional Learning at the University of Saskatchewan;
- Dr. Gill White, an Associate Dean at the University of Saskatchewan; and
- Dr. Gregory Marchildon, Executive Director of the Commission on the Future of Health Care in Canada.

Interviews with Dr. Dennis Kendel, Dr. Ian Bowmer, Dr. Penny Davis, and Dr. Gill White were tape recorded.

4.2. Research Questions

Issue 1

Why does recognition of foreign medical credentials by medical regulatory organizations continue to constitute a barrier to IMGs´ medical practice in Canada? What relationship exists between the CPSS and the SMA and what influence, if any, does the SMA have on the CPSS regarding the establishment of regulations for IMGs and health care professionals in general?

Issue 2

What new provisions did the revised AIT Labour Mobility Chapter introduce to reduce or eliminate barriers to mobility of health care professionals? What other alternative approaches (if any) might there be to accomplish full, unhindered, labour mobility across Canada?

Issue 3

How did the EU reach a consensus on automatic recognition of physicians´ qualifications? What kind of negotiations preceded this provision? Can/should the EU experience serve as an example for Canada?

Chapter 3

Licensure of IMGs in Canada

1. Introduction

IMGs sometimes find out, after many years of study, passing numerous examinations, and undergoing medical training, that they cannot enter into medical practice in Canada—the main reason being non-recognition of their qualifications. While in some countries recognition of foreign medical credentials is rather a formality, other countries have set very high requirements for registration with a licensing body. Most countries apply either a self-regulatory or a government-regulated model to the medical profession, the main difference being their understanding of the "contract" between professionals and society at large. In most Commonwealth countries, including Canada, professionals are seen as serving primarily the public. In Europe, on the other hand, the foremost contractual obligation is that between professionals and the state. Therefore, while the medical profession in Canada is regulated by the profession itself, in Europe it is the state that regulates the professionals (Dahrendorf, 1984, p. 179 – 180). In other words, while in Canada the medical profession is self-governing (independent), in Europe it is the state that guarantees the contract between the medical profession and society. In the Canadian context, then, effective licensure policies depend primarily on regulators, not on civil servants.

The first section of this chapter explains the different value of medical credentials acquired around the world as perceived in Canada by drawing on Canada´s history as a British colony, mainly because Canada has always accepted the British model of licensure. The second section then builds upon the first section and investigates two possible routes for IMGs to obtain a medical licence in Canada. Finally, the third section focuses on the CPSS

and the SMA; it examines their historical developments, interests, their current relationship, and the influence the SMA may have on the CPSS´s policies regarding IMGs´ licensure.

2. Different Value of Medical Credentials Acquired Around the World

Recognition of immigrants´ qualifications acquired abroad has become a central issue for immigrant settlement policy in Canada for three reasons: (1) Canada´s continuing commitment to mass immigration, (2) Canada´s ineffective institutional means for assessment of immigrants´ qualifications, and (3) the significantly lower employment prospects of new immigrants in comparison with Canadians. The issue of immigrant skill under-utilization has represented not only an economic problem for Canada, but it has also created social and political pressures (Reitz, 2004, p. 2 – 3).

Non-recognition of IMGs´ credentials has not been an exception. As a British colony, Canada was heavily influenced by the medical licensure policies adopted by the UK General Medical Council (GMC). In all Canadian jurisdictions, with the exception of Quebec, physicians who achieved registration with the GMC were essentially guaranteed licensure eligibility in Canada. Consequently, while physicians coming from some of the present and former Commonwealth countries such as the UK, Australia, New Zealand, South Africa, and Ireland, have been given preferential eligibility for registration, physicians from other countries have been left out of the system (Kendel, 2011a, p. 3).

According to the Association of International Physicians and Surgeons of Ontario, the main problem of fairness in the evaluation of professionals´ credentials arises from the criteria being used. Emphasis is often put on the process of acquiring professional skills rather than the skills themselves. But because the process says nothing about the professionals' actual qualifications, a large number of fully trained international physicians with foreign medical credentials and foreign medical practice have to undergo the whole process of accreditation again (AIPSO, 2000, p. 4).

Progress has been achieved with regard to recognition of under-graduate degrees issued by almost all medical schools. However, recognizing the equivalency of post-graduate medical education[21] has remained a significant problem, mainly because of the scarcity of truly effective accreditation programs around the world. In some countries physicians have been permitted to commence independent medical practice immediately after completing their under-graduate medical education. In other countries post-graduate training has consisted of nothing more than unstructured apprenticeship programs and no mechanisms have been created to assure that explicit educational goals are achieved during those post-graduate learning activities. As a result, it has proven absolutely impossible to objectively measure the quality of post-graduate education in many countries (Kendel, 2011a, p. 3 – 4).

This problem has been recognized for many years but it has become a controversial issue especially given the change in continents from which the majority of today´s IMGs arrive in Canada. While in the 1970s, 30% to 35% of Canada´s physicians were foreign-trained and came mainly from South Africa, the UK, and Western Europe, 72% of all foreign-trained physicians in 2002[22] received their degrees in Asia, Eastern Europe, or the Middle East (Dove, 2009, p. 121). The motivation to develop fast, fair and accessible credential recognition has increased given the expectation that by 2011 immigrants will account for 100% of net labour market growth (Alboim & McIsaac, 2007, p. 3; MOSAIC, 2006, p. i).

On the other hand, it is important to note that the system of credential recognition itself has not been the only reason for refusal to recognize IMGs´ qualifications. In many instances, IMGs have actually proved unable to meet Canadian professional (occupational) standard (Zong, 2004, p. 81), and have been legitimately denied licensure. And while non-recognition

[21] From now on, the term "post-graduate medical education" will be used interchangeably with the term "post-graduate training" (in medical profession called residency training).
[22] In 2002, there was 23% foreign-trained physicians in Canada (CIHI, 2009, p. 38).

of physician qualifications and the inability to meet Canadian occupational standard cannot be considered in isolation, one of these factors always dominates, leading to a laborious licensing process (Basran & Zong, 1998, p. 10).

3. Licensure of IMGs – Assessment Procedure

One of the possible ways for IMGs to obtain a medical licence in Canada is through assessment programs approved by the RCPS or the CFP and administered by the College of Physicians and Surgeons. However, as already mentioned, recognition of foreign medical credentials from countries where the accreditation programs have been either considered insufficiently rigorous or have been unknown to the Canadian medical regulatory authorities has not been resolved yet. Therefore, this path to licensure has so far been made accessible only to IMGs with qualifications obtained in the UK, Australia, New Zealand, South Africa, and Ireland.

Section 3 of this chapter focuses on the assessment process. First, it examines challenges even the IMGs currently "eligible" for an assessment have to face when pursuing a full medical licence. Second, it introduces a new Saskatchewan-based initiative, which attempts to make the process of assessment not only more inclusive, but also more effective.

3.1. The Current Assessment Process

IMGs who complete their post-graduate training in one of the four Commonwealth countries or Ireland are considered to have equivalent post-graduate education to Canadian programs. In spite of that, even these IMGs have to undergo a minimum of three to six months of a residency program, which assesses their suitability to practise independently. Only after the successful completion of this program and passing the CFPC or RSPSC

certification exams are IMGs issued a restricted licence[23], allowing them to practise in under-served areas (McGrath, Wong, & Holewa, 2011, p. 7).

According to Dr. Gill White (2011), the purpose of the special assessment residency program is valid but the timing is not: IMGs undergo this assessment only after they have already begun their practice in the under-served area. IMGs practising in remote and rural areas of Saskatchewan apply to the University of Manitoba Clinicians´ Assessment and Professional Enhancement (CAPE)[24] program. They prepare for the CAPE examination and then leave the province to get assessed, all while building their actual practice (Saskatchewan Ministry of Health, 2010a, p. 1). The CAPE results then determine if the IMG has the medical knowledge and skills required for holding a medical licence in Saskatchewan. After that, the successful candidates have five years to complete the MCCQE1[25] and MCCQE2[26], and seven years to obtain the Certificate from the CFPC (Government of Manitoba, 2006). The unsuccessful ones, on the other hand, have to go through remedial training and leave the rural communities. Rapid physician turnover and discontinuity of medical care affect both physicians and patients located in rural communities (White, 2011).

Furthermore, since a provisional licence often serves only as an expeditious route for IMGs to obtain a full medical licence (Dove, 2009, p. 121), discontinuity of medical care has really become a major concern for medical regulatory organizations. IMGs are likely to remain in under-served areas only up to their successful completion of their licensing exams and then leave for a more lucrative practice in wealthier urban areas (Audas, Ross, & Vardy,

[23] This licence is sometimes called provisional, temporary, or conditional.

[24] The CAPE assessment process consists of four components: (1) multiple-choice questions, (2) structured oral interview, (3) therapeutics assessment, and (4) a clinical comprehensive encounter using standardized patients (University of Saskatchewan, 2008, p. 3). It is not a resident assessment program in the context that residents are students in training; it is an assessment program mainly for determining eligibility for practice (White, 2011).

[25] MCCQE1 is a computer based examination that measures knowledge, clinical reasoning, and clinical problem solving skills (Kendel, 2011a, p. 2).

[26] MCCQE2 is an Objective Structured Clinical Examination (OSCE) during which physicians are observed in their interactions with trained actors who simulate patients in clinical situations. This examination tests the capacity of physicians to perform effectively in simulated clinical setting instead of merely testing their knowledge (Kendel, 2011a, p. 2).

2005a, p. 110; Mathews, Edwards, & Rourke, 2008, p. 37). Evidently, even the IMGs who pass the CAPE sometimes create a disruptive situation.

3.2. Improved Assessment Process for Family Medicine

To amend this situation, a new assessment process became a priority for all, provincial governments, professional regulatory organizations, and medical associations. The Government of Saskatchewan has been on the front line, mainly because 55% of those practising medicine in Saskatchewan are IMGs (Health Edition, 2010). In the 2008 Throne speech, the Government of Saskatchewan made a commitment to improve the current assessment process to address the physician shortage in the province. Dr. Gill White obtained a $500,000 federal grant to develop and pilot this new process. Administered by the College of Medicine at the University of Saskatchewan, this new assessment process is currently in its pilot phase (Kendel, 2010, p. 2). Once that phase has been completed, and (if) the Government of Saskatchewan approves it, the old CAPE assessment will be replaced (Davis, 2011).

3.2.1. Fundamentals of the New Process

The new assessment process will be offered three to four times a year. During each cycle, IMGs will receive a very comprehensive orientation phase to help ensure that they succeed in the centralized assessment[27]. Those IMGs who succeed in the centralized assessment will then proceed to a community based assessment[28] in a community other than that of their eventual practice location. The entire assessment process will result in a pass/fail

[27] The centralized assessment takes several days and uses a variety of tools such the OSCE, a pharmacology exam, and EPAK (Evaluation of Physician-Applied Knowledge). Those who succeed in the assessment will move to the second orientation teaching IMGs about the Saskatchewan medical system (Saskatchewan Ministry of Health, 2010a, p. 4).

[28] The community (clinical) field assessment may take as little as three weeks or as long as twelve weeks at the discretion of an assessor who ultimately decides if a certain IMG has the requisite knowledge, skills, and capacity to practise safely (Kendel, 2010, p. 2). The clinical field assessment uses tools such as the mini-Clinical Evaluation Exercise (mini-CEX), In-Training Evaluation Report (ITER), and chart-guided reviews (Saskatchewan Ministry of Health, 2010a, p. 4).

outcome for each candidate (Kendel, 2010, p. 2). Although IMGs who pass the assessment will obtain only a provisional licence to practice, they will be able to obtain a full registration status with the CPSS once they acquire the Licentiate of the Medical Council of Canada (LMCC)[29] and the CFPC Certification (Kendel, 2010, p. 2). Ultimately, the idea is that there will also be a process replacing the MCCQE1 and MCCQE2 (Davis, 2011). However, because that will have to be a national decision made by all Colleges of Physicians and Surgeons across the country, it may take some time to achieve.

3.2.2. Benefits of the New Process

The new assessment process should improve things on a number of fronts. It was designed to allow not only the recruitment of more IMGs but also a recruitment that would be more effective. First of all, IMGs from *all* countries will be assessed as long as they meet the pre-screening criteria[30]. Opening up the assessment process to IMGs from all around the world will allow provinces to recruit a much wider range of foreign-trained physicians. Second, while the CAPE examination took place only every few months and evaluated only about 55 physicians a year, the new assessment process will have three intakes and a capacity to assess approximately 90 IMGs a year (Saskatchewan Ministry of Health, 2010a, p. 1, 3). Third, all IMGs will be assessed prior to their independent practice, which will ensure safer and higher quality patient care and uninterrupted health care delivery (Bottrell, 2010). Fourth, the new assessment will provide orientation to the Canadian practice environment for all IMGs prior to their actual assessment. IMGs will therefore be able to adjust to practice in the province and increase their chances of success in the assessment (Saskatchewan Ministry of Health, 2010a, p. 2). Finally, the new approach will align Saskatchewan with national

[29] See Glossary.

[30] To fulfill the pre-screening criteria IMGs will have to be from a WHO-recognized medical school, have at least one year of family medicine post-graduate training, three years of current family medicine experience, the MCCEE, an English-language proficiency exam score of 100 or above, and references (Davis, 2011; Saskatchewan Ministry of Health, 2010b, p. 4).

licensure standards currently under development, allowing for enhanced labour mobility between provinces (Health Edition, 2010).

3.2.3. Potential Pitfalls

Although the new assessment process has many benefits, it has also two possible shortcomings. First of all, all the costs associated with the assessment during the pilot phase are paid by the government. However, once the pilot phase is over, IMGs will have to pay a fee[31] to get through the assessment. According to Dr. Penny Davis 2011, the health regions might offer to pay all up-front and then get repaid afterwards but, as she admits, it might, in the end, keep some IMGs from applying.

Second, some IMGs might be reluctant to apply for the new assessment as a consequence of not knowing what to expect or how effective the new system will turn out to be. As one IMG put it, "I´d rather not be the first to do a new system, in case there are any pitfalls or problems they didn´t foresee. I´d rather not be one of the guinea pigs" (Hill, 2010). Nevertheless, since the assessment is only in its initial phase, one can only speculate for now what results it will bring.

4. Licensure of IMGs – Post-Graduate Training

The second possible way for IMGs to obtain a medical licence in Canada is through post-graduate residency training. This applies to IMGs who have either received their qualifications in countries other than the UK, Australia, New Zealand, South Africa, and Ireland, or to IMGs who have not yet completed their post-graduate training. Section 4 of this chapter examines the licensing path through post-graduate training. The process varies slightly from province to province. Saskatchewan will be used for this section.

[31] The actual amount of the assessment fee has not been determined yet. However, as Dr. Penny Davis stated, it will probably be at least a couple of thousand dollars (2011).

4.1. Licensing Path

Generally, there are five main requirements every IMG has to fulfill before he/she can receive a Certificate of Registration[32]:

4.1.1. An Undergraduate Degree from an Accredited University

First of all, every IMG aspiring to practice medicine in Canada has to have an undergraduate medical degree from an accredited university listed by the Foundation for Advancement of International Medical Education and Research (FAIMER) (Dumont et al., 2008, p. 54). This step is important especially because there are significant differences between medical degrees from international medical schools. In terms of content and quality, some medical students are exposed to many medical disciplines and significant patient contact for seven to eight years; others, on the other hand, go through programs as short as four years of primarily book and lecture-based training with no patient contact. In terms of admission criteria, some medical schools allow any first year university student to enter medical training; others, on the other hand, have a very competitive entrance process with candidates selected only after a successful completion of pre-medical school university training (VanAndel, 2007, p. 1).

Second, all IMGs have to send their medical credential documents to the MCC´s Physician Credentials Repository (PCR) for source verification (MCC, n.d.). The MCC provides a unique interface between the IMG and the practising physician. It constitutes the only formal forum for the educational institutions and the regulatory authorities of the medical community. Since 1912, both groups have been regularly coming to the MCC´s table to discuss and assure standards of competence for IMGs who are allowed to practise medicine in Canada (Vodden, 2008, p. iii).

[32] See Glossary.

4.1.2. Post-Graduate Medical Training

The second step to obtaining a medical licence requires every IMG to successfully complete post-graduate medical training accredited by the RCPS and the CFPC (CFPC, 2010). The Canadian Residency Matching Service (CaRMS)[33] and IMG-specific programs are the main points of access into this training (MCC, n.d.). IMGs are matched with residency programs through two matching procedures (iterations)[34] (CaRMS, 2010a). In spite of a very similar matching process for CMGs and IMGs, IMGs experience far more difficulties getting into a residency program, especially because of the limited number of residency training positions available to them (Audas & Ross & Vardy, 2005b). As Dr. Kendel (2011a) puts it, "the surplus capacity in Canadian residency programs currently runs around 15% above that needed to accommodate Canadian medical graduates" (p. 4). Not surprisingly, then, the CaRMS 2010 statistics indicate that while more than 96% of CMGs were matched in the first round, only 23.5%[35] of IMGs were matched (CaRMS, 2010b). Moreover, 48% of the matched IMGs were Canadians who obtained their medical degrees abroad (CSAs) (Collier, 2010). On the other hand, the number of positions reserved for IMGs increased substantially from 23 in 1995 to 39 in 2000, to 80 in 2005 and finally to 353 in 2008 (Dumont et al., 2008, p. 56). But as Dr. Ian Bowmer (2011) states, "we really don´t have a lot of positions available even now, although there are many more (...). Governments have added more positions but they haven´t added the number that would be required to get all the physicians applying into a residency program".

It is important to note that CaRMS does not differentiate between foreign-born IMGs and CSAs, and neither should the program directors who make the final decision about who

[33] CaRMS is an administrative body, which places applicants into Canadian residency programs (CaRMS, n.d.).
[34] Prior to 2007, only CMGs were permitted to apply for the First Iteration Match positions; the IMGs were restricted to the Second Iteration Match. Since 2007, both the first and second iteration consists of two parallel streams, a Canadian Medical Graduate (CMG) stream and an IMG stream. Each stream has its own designated spots, which are not transferable (CaRMS, 2010a).
[35] That is a 6% drop from 2009 (CaRMS, 2010c).

gets into residency training (Banner et al. in McMahon, 2009, p. 11). Yet, program directors are often able to identify foreign-born IMGs from CSAs—many foreign-born IMGs are older, graduated from medical school earlier, and may have already practised in another country (McMahon, 2009, p. 11). The fact that program directors put a high premium on people who come all the way through the Canadian education system, know Canadian culture, and do not have to adjust to a new medical environment is neither surprising nor illogical. However, although evidence shows that IMGs do place a considerably high burden on residency programs because of the additional cultural training they require (Childs & Herbert, 2007, p. 9), the question remains to what extent (if any) should logic precede fair treatment.

4.1.3. The MCC National Exam

All IMGs have to demonstrate their medical knowledge by passing the MCC national exam, comprising the MCC Evaluating Exam (MCCEE[36]), the MCC Qualifying Examination Part 1 (MCCQE1), and the MCC Qualifying Examination Part 2 (MCCQE2) (Saskatchewan Immigration, 2009, p. 1 – 4). And while all graduates have to pass the MCCQE1 and the MCCQE2, the MCCEE—requiring a mark of 93% or above—is mandatory only for IMGs. Furthermore, pass rates for the MCCEE vary significantly among the CSAs with less than a one percent failure rate in the MCCEE and the foreign-born IMGs with a failure rate up to 80% (McMahon, 2009, p.8).

With regard to MCCQE1 and MCCQE2, foreign-trained physicians are often disadvantaged by being a long time away from a medical school, their age, language comprehension, and lack of familiarity with the Canadian medical training. Consequently, the

[36] MCCQE is a screening computer based examination developed by the MCC at the request of the Government of Canada to screen the medical knowledge of IMGs coming to Canada (Kendel, 2011a, p. 2). It is a general assessment of the IMG´s basic medical knowledge in the basic disciplines of medicine: child health, maternal health, adult health, mental health and population health and ethics. This examination assesses the knowledge and skills at the level of a Canadian-educated medical graduate competent to enter the first year of supervised post-graduate education in Canada (McMahon, 2009, p. 7 – 8).

success rate of CMGs and IMGs is strikingly different. While approximately 95% of CMGs pass the exams, only 21% of the IMGs do (Tyrrell & Dauphinee, 1999, p. 18). Likewise, the MCCQE statistics show that IMGs perform less well in these exams than CMGs (College registrars from all provinces except New Brunswick, 2009, p. 7 in McMahon, 2009, p. 8). However, it is fair to say that the MCCQE results only indicate that CMGs are better prepared for the exams than IMGs. Tyrrell and Dauphinee 1999 explain this phenomenon by Canada's demanding accreditation for its medical schools through the CFPC and the RCPSC. According to them, since only few countries have such a high standard of accreditation as Canada, it is not surprising that the success rate of IMGs taking the examinations is so low (p. 19 – 20).

4.1.4. Certification Exam

In some provinces, IMGs have to pass a certification exam. For family physicians[37] it is the CFPC Certification Examination while for specialists[38] it is the RCPSC Certification Examination depending on their specialty (MCC, n.d.). Once completed, IMGs can finally apply for a licence by submitting an application to a registrar of a province (Dumont et al., 2008, p. 57).

4.1.5. Conclusion

It is obvious that the journey from being an IMG to becoming a fully licensed physician entitled to practise in Canada is very demanding. Inflexible educational structure, excessive medical examinations, limited number of residency training positions, and the necessity of large financial commitments when pursuing a medical licence are requirements frustrating for

[37] Only from Alberta, British Colombia, and Ontario (Office of the Fairness Commissioner, 2010).
[38] Only from Alberta, British Colombia, Ontario, and Saskatchewan (Office of the Fairness Commissioner, 2010).

many IMGs. According to Laurel Broten[39] (2008), the path to licensure makes the medical profession inevitably stuck "in a time and place of isolation and closed door restrictions" (p. 7).

Post-graduate medical education is essential for obtaining a medical licence. Thus, a question arises why the provincial governments do not fund more residency training positions to accommodate more IMGs. In Canada, one can only operate a residency program if the government approves it and funds it. Since all residencies are attached to universities, it is not possible for hospitals to do their own residency programs (as it is common in the US). Increasing the number of provincially funded IMG residency positions would not only help integrate more IMGs into the Canada´s health care system, but it would also help ensure that there is equity in the process of becoming licensed. Dr. Kendel (2011b) affirms that residency programs are expensive but, he says, "if you get a practising physician out of them, it is a very good investment. If there was another ten percent extra residency capacity, it would make a huge difference". However, governments have so far been refusing to fund more residency training positions. Whatever reason stands behind such a decision, it may be about time that unemployed IMGs are considered as a component of a sustainable Canadian physician workforce.

5. Professional Regulatory Organizations

As a result of physician shortages in many areas in Canada, health care authorities have been under constant pressure to license more IMGs. However, according to Competition Bureau findings, most self-regulated professions maintain very high entry qualification requirements (2007, p. viii). While there certainly is a need for entry requirements assuring quality in the provision of professional services, any required entry qualifications should be justified as being the minimum reasonably protecting the patient. Since the standards are set

[39] Laurel Broten is the current Minister of Children and Youth Services and Minister Responsible for Women's Issues in Ontario. She has also worked on the integration of IMGs in Ontario.

by the Colleges of Physicians and Surgeons, this section examines the historical development, interests, and mandates of the CPSS—the main regulator in Saskatchewan, and the SMA—the main lobby group for health care professionals in the province.

5.1. Historical Development of the CPSS and SMA

The appropriate role of professional regulatory organizations and medical associations has been defined, refined, and redefined many times. The necessity of redefining the role of these bodies has grown with the changing expectations of the public and professionals (Bryce & Bayne, 2010, p. 3). The Council of the College of Physicians and Surgeons (CCPS), and the SMA were organized as two separate bodies in the early years of the province. In 1934, the CCPS was given statutory functions by The *Medical Act* for registration, licensing, and discipline. In the next years, however, it expanded some of its activities and transacted business with governments on behalf of the profession. That led to a conflict of authority and jurisdiction between the CCPS and the SMA which was trying to conduct business on behalf of the profession as well. Consequently, the CCPS and the SMA appointed a committee to resolve the friction. Based on the committee's suggestion to have only one body transacting all business on behalf of the profession, the two bodies merged in 1936 and adopted a common name—the CPSS. Accordingly, the SMA ceased to function (SMA, 2009a).

The CPSS then not only regulated the medical profession on behalf of the public, but it also promoted the doctors' economic interests. Yet, in the 1950s, the feeling started to arise that the CPSS should restrict its powers to registration, licensing, and discipline, and that the activities pertaining to economic and education should be undertaken by a separate organization to avoid compromising the CPSS´s position under the *Medical Profession Act, 1981*. Consequently, the CPSS appointed a Board of Saskatchewan Division (BSD), which in 1966 began to use the name Saskatchewan Medical Association (SMA, 2009a).

From 1967 to 1972, the SMA continued to operate under a grant from the CPSS. In 1972, the Government of Saskatchewan amended the Medical Profession Act to stop the CPSS from collecting dues on behalf of the SMA. The Government of Saskatchewan stepped in only for one reason—a rising perception that licensing physicians, while representing their economic interests, had generated a conflict of interest for the CPSS. Thus, the SMA became a separate entity for the second time (Baergen, 2006), and that has remained unchanged until today.

5.2. Interests of the CPSS and the SMA

Public interest is one of the main principles underlying health care regulations (Conference Board of Canada, 2007, p. 7; CPSS, n.d.,a). Accordingly, the CPSS must ensure that regulations affecting the practice of medicine serve and protect the public (CPSO, n.d.). In spite of that, members of the CPSS do face situations in which their private interests interfere with their professional conduct. Such a conflict often arises when their interests conflict with their professional judgment (MOHLTC, 2005, p. 1 – 2). Furthermore, since health care regulations have often been characterized by inconsistency and lack of clarity (Conference Board of Canada, 2007, p. ii), the challenge has always been to determine what regulations are really necessary to protect the public.

5.2.1. Does Private Interest Explain Overly Demanding Regulations?

The fact that self-regulation may be self-serving and abusive to the public has posed one of the major threats to the medical profession (Cruess & Cruess, 2005; Stephen & Love, 1999, p. 989). Nuno Garoupa[40] (2006) supports this view by noting that "it is difficult not to expect that professional bodies use their regulatory powers to restrict competition somehow" (p. 11). In the same vein, Janet Carson[41] (2001) argues that although individual professionals

[40] Nuno Garoupa is a Professor of law and economics at the University of Illinois.
[41] Janet Carson is a member of the National board of Medical Examiners.

"are not competing with each other for a limited number of licenses (...), [they] are competing with each other for a limited number of jobs" (433). The argument goes that because health care has become such a major industry, commercial interests increasingly pressure health care professionals to compromise their responsibilities, and protection of the public has thus been difficult to achieve. As a result, regulators may restrict entry into the profession as a consequence of a fee-for-service compensation model[42].

In 2007 the Competition Bureau conducted a study on self-regulated professions, concluding that although self-regulatory organizations may argue for high standards to ensure quality of the professionals´ services by setting educational, training or experience requirements, these restrictions actually limit the supply of professionals by affecting their ability to join and engage in the profession[43]. Furthermore, high standards may also limit patients´ access to treatment as a result of insufficient supply of professionals, which would benefit the practising physicians not only by lessening the competition among them, but also by increasing their financial benefits (p. 23 – 24).

However, the main purpose of regulations is to serve the public by limiting the ability of less qualified individuals to engage in the profession. These policies are embedded in bylaws adopted by the Governing Council of the College under the *Medical Profession Act, 1981*, which demand that the CPSS protect the public as its first priority (Section 69.1). The CPSS registrar Dr. Dennis Kendel explains,

> These bylaws must be approved by the Minister of Health before they come into force. Before approving a bylaw adopted by the CPSS, the Ministry of Health consults a broad range of stakeholders including other professional regulatory bodies in the health sector, the Regional

[42] The fee-for-service compensation model is likely to lead to reduced income for the profession with an increase in the number of licensed physicians.

[43] An example of such a restriction would be lengthening of the required post-graduate education. Regulators would affect the number of entrants into the profession by increasing the cost, both in terms of income (instead of working, professionals would be in school) and direct educational expenditures (Competition Bureau, 2007, p. 23).

> Health Authorities, and the SMA (...). The Ministry of Health has shown integrity by ensuring that it supports regulations which are in the public interests and is very careful to not be influenced by physician self-interests (2011a, p. 6 – 7).

Public interest is not limited to public protection. It also includes fair access to licensure, which increases ethnic diversity in a profession. "Discrimination" based on the country of IMGs´ post-graduate education is thus not justifiable. As indicated in the landmark March 2006 MOSAIC report on access to licensure in regulated professions called *Solutions for Access*:

> Discrimination is contrary to the public interest. As part of their duty to protect the public interest regulators have a duty to ensure that standards, assessment tools, and procedures are consistent with the human rights norms of non-discrimination and equality (...). Discrimination is a question of adverse effects rather than a question merely of form or intention (...). A requirement may be discriminatory because it is based on a standard that has adverse effects (...). The question is not whether stringent standards of competence are necessary, but whether particular standards, assessment tools and/or procedures that have the effect of excluding people from licensure, or of placing burdens on them because of their place of origin are necessary (p. iv).

It is important to note that while it is the CPSS that is responsible for adopting regulations and occupational standards, it is the SMA that is recognized by the Government of Saskatchewan as a bargaining agent, representing and promoting its members´ interests (CNHC, n.d.). Therefore, it would be logical to expect the SMA rather than the CPSS to try to restrict competition. However, the SMA has limited influence in this regard. Along with a whole number of organizations, such as the government, regional health authorities, regional municipalities, and individual communities, the SMA is only one of many parties allowed to give the CPSS recommendations (Kendel, 2011b). Moreover, it is important to note that the

College Council[44] consists of 32 to 34 members out of which 19 are physicians and 13 to 15 are members of the public (CPSO, 2011).

5.3. The Necessity to Involve All Stakeholders

The response to the question of how to effectively recognize foreign credentials has as many variations as there are individuals with qualifications earned outside Canada. And so, the federal government, provincial governments, regulatory organizations, licensing/accrediting organizations, professional associations, community agencies, and education institutions at different levels have developed various programs to assess foreign credentials in response to individual appeals. Unfortunately, seldom do these bodies cooperate with each other. The result is a number of procedures and programs that have few common reference points. That leaves IMGs often frustrated, under-employed, or unemployed (CAETO, 2004, p. 1). Unless all major stakeholders are determined to collaborate on a national level and reflect the system's needs, any significant progress in the area of credential recognition is unlikely.

6. Conclusion

In spite of the persistence of many barriers to the integration of IMGs into the Canadian health care system, awareness of the barriers has grown. The increased mobility of physicians around the world has particularly raised a number of concerns over the policies regulating licensure and recognition of foreign credentials. Ensuring that IMGs can use their knowledge, skills, and experience gained in the country of their education and training is in everybody´s interest especially because of the shortage of health care professionals in remote and rural areas in Canada[45].

[44] The Council is the governing body of the College.
[45] According to the Government of Canada´s 10-year labour market forecast, "the largest number of occupations showing signs of shortages at the national level is found in health sector" (HRSDC, 2009).

All agencies involved in the assessment and licensure process have a role to play. The federal government can provide incentive funding to the provinces. As John Samuel[46] (2004) indicated, such a funding could, for instance, help obtain information about the medical education and training in countries so far labeled as "inconclusive"[47]. According to Samuel, it would be enough to begin only with the top three or four countries where immigrant IMGs receive their medical training and cover all of them eventually. The provincial government could allocate funding for residency training positions to accommodate more IMGs. Furthermore, it could also expand its incentives (e.g. creating initiatives or providing funding) on the Saskatchewan-based assessment. Finally, the regulatory bodies could focus on improvement of their assessment and licensure methods. That would not only help further identify gaps in the educational background of IMGs, but it would also ensure greater consistency of retraining requirements for IMGs with similar education and experience.

Removal of barriers that prevent adequately qualified IMGs from pursuing their profession would benefit both IMGs and CSAs[48]. Therefore, both immigrants and Canadians have a stake in creating a labour market in which the mobility of professionals has been facilitated by the elimination of barriers to credential recognition.

Finally, one of the major findings of this chapter is that while many of the current problems regarding licensure have been blamed on professional regulatory organizations, they are often not to blame. First of all, the number of residency training positions restricted for IMGs is dependent on government funding. Regulators can recommend funding more residency positions to provide people with better access to the "right" supply and distribution

[46] John Samuel was Director/Chief, Migration and Demographic Policy/Strategic Planning, Employment and Immigration Canada (EIC).
[47] Inconclusive countries are all those other than the UK, Australia, New Zealand, South Africa, and Ireland.
[48] CSAs might experience the same problems associated with credentials as IMGs when they later return to Canada.

of physicians, but in the end it is the provincial governments that control the capacity of post-graduate medical education in Canada.

Second, awarding residency training positions is in the hands of directors of individual medical residency programs. As Dr. Kendel (2011a) explained, "Colleges of Physicians and Surgeons have no control over who gains access to post-graduate medical education in Canada and (...) [they] have no influence over the size of the post-graduate medical education system in Canada" (p. 5). The regulators cannot influence whether the directors of medical residency programs favour CMGs over IMGs.

Third, it is true that Colleges of Physicians and Surgeons have accorded preferential eligibility for registration to IMGs with credentials and qualifications gained in the UK, Australia, New Zealand, South Africa, and Ireland. And while it is an understandable bias, this practice will hopefully change with the new Saskatchewan-based evaluation process for foreign-trained family physicians. When implemented, employers will have confidence that they are hiring people qualified to do the job, and *all* IMGs will receive a faster and more efficient assessment providing them with a clear understanding of what, if any, additional training may be required of them.

Chapter 4

Inter-provincial Barriers to Physician Mobility

1. Introduction

"Labour mobility" refers to the freedom of workers to practice their occupation wherever opportunities exist. All Canadians enjoy a constitutionally guaranteed right to work in any part of Canada they choose, which imposes a duty on governments, regulators, and other competent authorities[49] not to erect unreasonable barriers that would compromise such a right (Torgerson, Wortsman, & McIntosh, 2006, p. 1). However, even though around 200,000 Canadians move to a different province every year to look for a work (HRSDC, 2010), barriers to labour mobility for regulated occupations[50] in Canada continue to exist.

Canadian governments tried to reduce the barriers through the AIT, signed between all Canadian jurisdictions in 1994, but the original version of that Agreement failed on a number of fronts (Knox & Karabegovic, 2009). Consequently, in 2006, the governments of Alberta and British Columbia concluded the Trade, Investment and Labour Mobility Agreement (TILMA) with the aim of eliminating many of the still existing interprovincial barriers. Inspired by the TILMA achievement, the First Ministers then endorsed amendments to the Labour Mobility Chapter of the AIT (Chapter 7) in 2009 to help resolve labour mobility barriers within regulated occupations between all provinces (Government of Saskatchewan, 2009). These amendments resulted in unrestricted mobility between all Canadian jurisdictions for anyone licensed to practise medicine in Canada.

However, because the revised AIT did not require reconciliation of the licensure standards applied by individual provinces, the College Council decided to go beyond the AIT

[49] See Glossary.
[50] See Glossary.

provisions and endorsed the Federation of Medical Regulatory Authorities of Canada (FMRAC)[51] Agreement on national standards with the aim of achieving common national standards for licensure adopted by all jurisdictions (CPSO, n.d.).

The aim of this chapter is to examine inter-provincial barriers to physicians´ mobility in Canada with a primary focus on barriers related to non-recognition of credentials and licenses. The chapter is organized as follows. The first section provides background information on provincial regulatory arrangements. The second section focuses on the AIT Labour Mobility Chapter, and assesses whether the amended version of the Labour Mobility Chapter has the potential to resolve Canada´s current labour mobility barriers. Finally, the third section attempts to deduce what the most effective method for breaking down the inter-provincial barriers could be, and considers alternative approaches to the complete elimination of the barriers.

2. Jurisdictional Regulatory Arrangements

One of the main reasons for inter-provincial barriers to labour mobility is the number of stakeholders involved in the credential recognition process. The constitutional division of powers in Canada means that the legal authority to set occupational standards and certification requirements lies with—by virtue of section 92 of the *Constitution Act, 1867*—the provinces, not the federal government. The regulatory powers have then often been further delegated to professional regulatory organizations whose highly educated and trained members have been deemed to be in the best position to judge their peers[52] (Blackmer, 2007, p. 9). As a result, there are not only approximately 60 regulated professions in Canada (HRSDC, 2010), but also about 400 regulating bodies (Becklumb & Elgersma,

[51] FMRAC is a national organization. It acts on behalf of all provincial medical regulatory organizations, both nationally and internationally. One of its goals is to deal with matters which involve licensure and/or regulation (FMRAC, 2010).

[52] Other bodies with various degrees of influence regarding the regulatory powers include credentialing bodies, provincial professional associations, and numerous stakeholders (OHA, 2003 In Baranek, 2005, p. 4; Conference Board of Canada, 2007, p. 7).

2008, p. 5). And although provincial governments have the obligation to establish occupational standards within their jurisdiction, they have no responsibility to reconcile these occupational standards, or even implement common national standards (Knox, 2010, p. 2). Consequently, Robert Knox[53] (2010) asserts, "this structure has all the impediments that multiple regulators and differences in qualification standards, regulations and occupational requirements can create" (p. 2).

It is important to note that physicians in Canada never explicitly lobbied for provincial regulatory arrangements. On the contrary, Dr. Thomas Roddick[54] foresaw the harm that could come if licensures were granted by each jurisdiction (Kendel & Dauphinee, 1994, p. 1579). Therefore, he lobbied the provincial governments to set a uniform level of medical qualifications (Vodden, 2008, p. 8). He believed that inter-jurisdictional barriers to physicians´ mobility could be overcome by creating a national agency that would issue a medical credential recognized for licensure by all Canadian jurisdictions. His efforts bore fruit in 1912 when Parliament finally adopted the *Canada Medical Act*, which established the MCC. The MCC was created under federal legislation to issue a medical credential—the LMCC—recognized everywhere in Canada; however, it was not assigned any licensing or regulatory power (Kendel, 2011a, p. 2). By statute, the authority to regulate the practice of medicine, including establishment of standards for licensure, has always rested with the provincial Colleges of Physicians and Surgeons.

3. The AIT Labour Mobility Chapter

The AIT was signed in April 1994 by federal and provincial governments with the aim of reducing or completely eliminating inter-provincial barriers to free movement of persons,

[53] Robert Knox is the Principal of R.H. Knox & Associates. He provides advice on domestic trade to private sector clients and commentary on internal trade issues and the AIT.

[54] Thomas Roddick was a Canadian physician, medical administrator, and parliamentarian. With the creation of the Medical Council of Canada in 1912, the CMA elected Roddick honorary president for life. He also served as the first president of the MCC from 1912 to 1914 and it gave him the first certificate of registration in 1913.

goods, services, and investment. The purpose of the AIT Labour Mobility Chapter was to "enable any worker qualified for an occupation in the territory of a Party to be granted employment occupations in the territory of any other Party as provided in this chapter" (AIT, 1995, Article 701). However, since the original version of the AIT did not meet all expectations, revisions became a priority.

Section three of this chapter first investigates what barriers regarding credential recognition of physicians moving from one province to another existed before the AIT Labour Mobility Chapter was revised[55]. Second, it looks at how the revised AIT Labour Mobility Chapter liberalized the movement of professionals and recognition of their credentials. Third, it assesses whether or not the revised Labour Mobility Chapter has the potential to dismantle the existing barriers to inter-provincial labour mobility.

3.1. Inter-Provincial Barriers to Labour Mobility Before 2005

The extent of current barriers to inter-provincial mobility for regulated workers in Canada is unclear (Knox, 2010, p. 6). As Dr. Kendel (2011a) points out, the reason for that is that there has been only a two-year effort to eliminate all inter-provincial barriers. Consequently, there is no statistical database documenting problems physicians might have experienced over these past two years with regard to recognition of their credentials (p. 11). Therefore, this sub-section uses a national report from 2004/2005—the most recent statistical information on inter-provincial labour mobility and compliance with the labour mobility provisions of the AIT[56]—to identify what barriers to labour mobility existed before 2005 to clarify why amendments to the AIT Labour Mobility Chapter were necessary.

[55] The reason for examining barriers to inter-provincial labour mobility only until 2005 is the non-existence of statistical data or information regarding the nation-wide compliance with the labour mobility provisions of the AIT and inter-provincial recognition of physician credentials after the implementation of the new, revised, AIT Labour Mobility Chapter in 2009.

[56] One of the limitations of this study is that the survey results do not specify which of the 50 regulated occupations that were surveyed had high registration rates and which of them had low ones. Consequently, it

In the winter of 2004/2005, the Labour Market Coordinating Group (LMCG), a committee of officials representing all Canadian governments, was tasked by the Forum of Labour Market Ministers (FLMM) with preparing a national report on labour mobility. Provincial governments were asked to survey their professional regulatory bodies on 16 questions related to compliance with the AIT, mutual recognition agreements [57], and registration information. Out of 425 regulatory bodies to whom surveys were sent, 392 responded (FLMM, 2005, p. 1).

The survey results showed that over the year ending September 30, 2004 regulators registered only 65% of workers across all occupations requiring credential recognition. In other words, out of 12,953 workers who moved within that one-year period from one jurisdiction to another, only 8,386 had their qualifications recognized and were issued a licence to practice. Furthermore, only 51% (815 workers) out of the 1,590 CSAs were registered by the receiving province (FLMM, 2005, p. 2). The FLMM also asked the regulators to explain why they refused to register those workers. While in some cases the applicants did not meet the standards of the destination province, in other cases the workers´ qualifications were not recognized because the regulators were either not abiding by the AIT provisions or were not complying with the terms of mutual recognition agreements. For instance, out of the 392 regulatory bodies, 31 (eight percent) said that an applicant had to be a resident of the new province in order to be registered[58]. Another 71 regulatory bodies (18%) reported that they had not changed their regulations and still needed time to accommodate all applicants who were qualified in other jurisdictions (FLMM, 2005, p. 2). As Robert Knox (2010) noted, "10 years after the AIT came into force, a significant number of regulators had

was not possible to determine how many physicians, out of all the regulated workers, were issued a licence to practise in another jurisdiction.

[57] See Glossary.

[58] However, already the 1995 version of the AIT Labour Mobility Chapter required that "no Party shall require worker of any other Party to be resident in its territory as a condition of: (a) access to employment opportunities, (b) licensing certification or registration relating to the worker´s occupation; or (c) eligibility for the worker´s occupation" (AIT 1995, Article 706).

ignored their obligations in the original Labour Mobility Chapter and provincial governments had not sought their compliance as they had undertaken to do" (p. 6).

However, with the increased importance of meeting shortages of skilled workers in remote and rural areas of Canada, removing barriers to inter-provincial mobility of professionals became a high priority for many policy makers. Furthermore, Rafael Gomez[59] and Morley Gunderson[60] (2007) stressed that unhindered inter-provincial mobility also has the potential to (1) foster internal efficiency as a pre-condition for external efficiency to promote productivity and competitiveness in global markets, (2) alleviate surpluses of under-employed and unemployed labour in the sending regions, (3) reallocate already existing skills as opposed to the costly and uncertain process of "producing" those skills through education and training, and (4) foster a more general labour market adjustment strategy[61] (p. 1 – 2).

To conclude, full labour mobility is not only a key mechanism of labour market efficiency, but it has also become an important element of Canada´s competitiveness in today´s knowledge-based economy. For that reason, the First Ministers endorsed amendments to the original AIT Labour Mobility Chapter with an expectation that the "amendments pave the way for further strengthening (…) [Canada´s] economic union" (Stephen Harper cited in CTHRC, 2009).

3.2. New Labour Mobility Chapter

In 2003 the Council of the Federation[62] (COF) announced one of its primary mandates: strengthening and full implementation of the AIT. In 2007, the COF reaffirmed provincial

[59] Rafael Gomez is an Associate Professor of Industrial Relations and Human Resources at the University of Toronto.
[60] Morley Gunderson is a Professor at the Centre for Industrial Relations and Human Resources, and Department of Economics at the University of Toronto.
[61] Mobility promotes adjustment in the direction of basic market forces and thereby improves situations in both sending and receiving province (Gomez & Gunderson, 2007, p. 2).
[62] The Council of the Federation was created in 2003 as a new institution to promote interprovincial cooperation and to ultimately strengthen Canada (COF, n.d.).

interest in creating freer internal borders and adopted a five-point plan for improving the AIT (Macmillan & Grady, 2007, p. 1). When referring to labour mobility the Premiers agreed,

> Governments must work to bring all regulated occupations into full compliance by April 2009, and direct Labour Market ministers to ensure resources are in place to facilitate negotiations and to develop a compliance and communications strategy so that all remaining regulated occupations are aware of this requirement. Premiers directed senior officials to provide them with a list of non-compliant occupations by December 2007. Premiers further agreed to consider legislative action to ensure full compliance, should some occupation groups fail to comply voluntarily (COF, 2007, p. 1).

Although the COF had a major influence on shaping the discussions on the elimination of inter-provincial barriers, the main recommendations were made by the FLMM. The final version of the revised AIT was approved by the Committee on Internal Trade[63] in December 2008 and endorsed by the First Ministers in January 2009 (Internal Trade Secretariat, 2009, p. 4).

3.2.1. Will the Existing Barriers to Labour Mobility Finally Cease to Exist?

The revised version of the Labour Mobility Chapter calls for full labour mobility in regulated professions in Canada. The obligations have not changed, that is to (1) reduce or eliminate measures that restrict labour mobility within Canada and (2) mutually recognize qualifications of any worker who moves from one jurisdiction to another. However, the approach and strategy of how to achieve this obligation have altered.

First of all, provincial governments are no longer required to reconcile differences in their occupational standards and certification requirements. To certify an applicant, a regulator only needs to know if the applicant is certified for that occupation by a legally

[63] The Committee on Internal Trade, made up of federal and provincial ministers, was created because of the AIT. It is responsible for internal trade and oversees the implementation and operation of the AIT (Industry Canada, 2009).

established regulatory body in another jurisdiction. In other words, mutual recognition is now the current standard practice, unless a government puts forward an acceptable reason for maintaining a barrier[64] (Knox, 2010, p. 5, 7 – 8). However, this specific provision has raised some concerns. FMRAC particularly expressed fear for patient safety if a physician, certified in one jurisdiction, is allowed to practise in another jurisdiction without any further training, examination, or assessment requirements (CPA, n.d., p. 2; COF, 2008, p. 2). Regulators have also worried that mutual recognition may ultimately lead to a lowering of professional standards in provinces which have previously had high standards, both because it would mandate entry for professionals trained below the standards of the receiving province and because accreditors may want to attract physicians (Nicolaïdis, 1997; Nilsen, 2009, p. 5).

These concerns are legitimate because licensing an applicant in a jurisdiction with "more liberal" registration policies could, under the AIT, serve as an entry point for that applicant into other Canadian jurisdictions where registration policies are more demanding. For this reason, the College Council endorsed the FMRAC Agreement on national standards for licensure. On the other hand, it is unlikely that accreditors would purposely lower their requirements to expand the number of physicians in their province. On the contrary, regulatory bodies have always emphasized the need for having constraints on competition to protect the public.

A second significant improvement in the revised Labour Mobility Chapter concerns the specific rules on what constitutes barriers to labour mobility. While all those rules, established in Chapter 4 of the AIT, were already defined in the original AIT, they now apply also to the Labour Mobility Chapter (Knox, 2010, p. 8). Based on Chapter 4, a barrier to

[64] To justify such a measure, the government (regulator) must demonstrate (1) that there is a material difference in the certification requirements and occupational standards between a jurisdiction where the worker has already been certified and a jurisdiction where a worker is seeking to be certified; and (2) that the difference will result in a deficiency of critical skills, knowledge, or ability required to perform the scope of practice for the occupation (AIT, 2009, Article 708(2)).

labour mobility is any measure that (1) discriminates[65] (AIT, 2009, Article 401(2)), (2) prevents a person from moving from one jurisdiction to another for the purpose of work (AIT, 2009, Article 402), and/or (3) creates an obstacle to mobility (AIT, 2009, Article 403). The hope is that such a definition will help determine when a government measure creates an obstacle to labour mobility. And while governments and regulators might still find loopholes in this definition, the chances for them not to abide with the Labour Mobility provisions are definitely reduced.

3.2.2. Possibility of Failure?

One of the main obstacles to ensuring effective governmental compliance with the original AIT provisions was a weak dispute settlement system, often described as having no teeth and being meaningless in a practical sense. Chapter 17 on Dispute Resolution Provisions did not allow individuals to institute complaints against governments, and even if the dispute resolutions did in the end make rulings against governments, governments had no obligation to implement dispute settlement findings made against them (Chamber of Commerce, 2008, p. 1; Macmillan & Grady, 2007, p. 6).

Consequently, the revised AIT set up a binding dispute settlement system with financial consequences, and allowed individuals to have direct access to a dispute resolution process (Nilsen, 2009, p. 5; Sinclair, 2007, p. 1). However, regulatory measures put forward by the health sector have been excluded from Chapter 17 on Dispute Resolution Provisions. The current dispute resolution process for the health sector requires all involved jurisdictions to negotiate a mutually acceptable settlement and share the costs of the process (Nilsen, 2009, p. 6). As a result, nothing has changed—physicians affected by barriers to mobility have at the

[65] Article 401(2) of the AIT: Reciprocal Non-discrimination, states, "each Party shall accord to persons, services and investments of any other Party treatment no less favourable than the best treatment it accords, in like circumstances, to: (a) its own persons, services and investments; and (b) persons, services and investments of any other Party or non-Party".

moment no direct role in dispute resolutions and no access to an appeal body to adjudicate their situation.

The second shortcoming of the revised AIT Labour Mobility Chapter is the Legitimate Objective provision (AIT, 2009, Article 708 and Article 711). This provision allows governments to maintain measures, normally impermissible under Chapter 7, if necessary to raise a legitimate objective. Although the legitimate objective exemptions are important for the protection of consumers, public health, security, and the environment, Robert Knox (2010) argues that, unfortunately, the revised AIT does not establish any formal process to validate the exceptions before they are posted as an official exception by the government that makes the claim. More importantly, he adds,

> Once the exception is posted, the only choice for a government or person who believes that an exception is not justified is to challenge the exclusion through the dispute resolution procedures (...). This is not a reasonable option. These procedures are complex, costly, time consuming[66] and ultimately difficult to enforce (p. 8).

Therefore, if governments want to meet the AIT objectives, they should first improve the functionality of the AIT dispute resolution system for health regulatory measures.

4. Provisions and Possibilities Beyond the AIT

Reaching a national consensus on any policy issue in Canada is difficult as provincial authorities have deeply rooted regional differences in perspective, often leading to inflexibility, irresponsiveness, and insensitivity to perspectives of others. However, in 2009, members of the FMRAC—the thirteen jurisdictional medical regulatory authorities—made a

[66] Consultations alone take up minimally four months. Furthermore, in case those consultations to resolve the issue fail, it takes 18 months from the time when a complaint was initiated to obtain a panel ruling (Knox, 2010, p. 8).

collective decision to define a common national standard for medical licensure across Canada, and established a Steering Committee to lead this process (Kendel, n.d.).

This alternative approach to breaking down inter-jurisdictional barriers to physicians´ mobility—defining a common national standard for licensure—is the main focus of section 4. Since this approach is based on "managed" mutual recognition[67], the first part of this section makes a connection between mutual recognition agreements and the AIT and explains variations in scope and automaticity of mutual recognition. The second part then moves to the concept of common national standards itself.

4.1. Mutual Recognition Agreements

The AIT spawned a number of mutual recognition agreements designed specifically to facilitate the movement of physicians from one jurisdiction to another by avoiding the duplication of re-assessment or re-qualification. The principles of mutual recognition agreements in Canada for occupations require that occupational standards reach a high level of commonality (e.g. 80%) according to two or more regulatory bodies which have been delegated by law to set the occupational standards (Torgerson & Wortsman & McIntosh, 2006, p. 7).

In 2001, the members of FMRAC signed a mutual recognition agreement to promote inter-provincial mobility and compliance with the original AIT. The signatories agreed that those physicians who (1) successfully completed their medical education, (2) underwent approved residency training, (3) demonstrated their language proficiency, (4) held Canadian citizenship, (5) proved good standing with prior and current jurisdictions, and (6) actively practised, could move freely between provinces. The FMRAC mutual recognition agreement thus recognized the numerous routes to obtaining a licence to practise medicine in Canada.

[67] The term "managed mutual recognition" was first used by Kalypso Nicolaïdis, Chair of South East European Studies and Lecturer in International Relations at Oxford University. This term is explained later in this section.

As a result, no single national standard was then established (McGuinty, Caplan, & Milloy, 2009, p. 4). In other words, the Agreement only required that the receiving province *takes into account* qualifications obtained in another province. Consequently, lack of predictability and room for arbitrary behavior on the part of the receiving province remained (Nicolaïdis, 1997).

However, in 2009, with the implementation of the revised AIT, common licensure standards for physicians became an urgent priority, the main reason being the mutual recognition principle introduced in the revised Labour Mobility Chapter. Regulatory bodies knew that due to migration patterns for physicians in Canada, provinces with net losses would adopt lower licensure standards to meet their medical human resources needs in comparison to more affluent provinces with net gains, which established more selective licensing policies (McGuinty, Caplan, & Milloy, 2009, p. 5). Therefore, regulatory authorities decided to set up a system which would provide for *automatic recognition of qualifications*. Although the revised AIT did not compel provinces to develop common licensing standards, it did provide a very strong incentive for the medical regulatory authorities and provincial governments to do so.

4.2. Defining Common National Standards for Licensure Through FMRAC

FMRAC and its members have been working together to document and standardize the various practices used by provincial medical regulatory bodies for registration and licensure. The intent has been to achieve uniformity in purpose and procedures regarding licensure, thereby facilitating the mobility of physicians (FMRAC, 2009, p. 1).

Initially, the FMRAC Steering Committee introduced a broad set of principles which it deemed appropriate to guide and inform the development of national medical licensure standards. These principles were confirmed at the FMRAC Annual Meeting convened in Halifax in June 2009 by all members of FMRAC except for the College of Physicians and

Surgeons of New Brunswick, which did not participate. Based on the feedback provided at the FMRAC Annual Meeting, the Steering Committee fine-tuned those principles and translated them into a draft agreement, which was approved and signed by all registrars with the exception of New Brunswick in October 2009 (Kendel, n.d.).

First of all, the Steering Committee defined the Canadian standard, requiring every applicant to:

> (a) have a medical degree from a medical school listed in the FAIMER´s International Medical Education Directory or the WHO´s World Directory of Medical Schools; and
> (b) be a Licentiate of the Medical Council of Canada; and
> (c) be certified by the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada (FMRAC, 2009, p. 2).

Medical regulators begun developing the national standard for registration of physicians even before the adoption of changes to the AIT Labour Mobility Chapter; however, the timelines were accelerated as a consequence of the need to comply with the AIT. Although similar standards have been used by almost all regulatory bodies, the vision was for every medical regulatory authority across Canada to use the same categories and definitions for full and provisional licences, to apply the same conditions prior to licensure, and to apply the same conditions for any later change to the status of a physician´s licence (Lefebvre, 2009).

As for IMGs, the Steering Committee realized that requiring all IMGs, especially those already at mid-career, to successfully complete all exams leading to licensure is not reasonable. The Steering Committee agreed that while all IMGs should prove that they possess foundational medical knowledge through successful completion of a screening exam such as the MCCEE, other evaluation tools should be more "fit for purpose" by rather using

practice assessment, the format and content of which would be approved by FMRAC and its members (Kendel, n.d.).

The Steering Committee also took the position that it is necessary to have a mechanism in each province for provisionally licensed IMGs to acquire a full medical licence through a process that does not require completion of exams currently offered by the MCC, the RCPS, and the CFPC. While IMGs would still have an opportunity to obtain full licensure through successful completion of those exams, they would also have an option of acquiring full licensure through (1) satisfactorily completion of a period of supervision in a Canadian jurisdiction, and (2) satisfactorily completion of a summative practice assessment in a Canadian jurisdiction (FMRAC, 2009, p. 6). According to Dr. Fleur-Ange Lefebvre[68] (2009), this "nationwide agreement on what constitutes a full and provisional licence will achieve the goal of the AIT".

Accordingly, the Colleges of Physicians and Surgeons across Canada started working together to align, to the greatest extent possible, their medical licensure and registration standards to achieve a common standard which would be applicable across the country. Dr. Kendel (2011a) notes an example of this transition:

> I would note that until April 1, 2011 IMGs have been able to commence medical practice in Saskatchewan on a temporary license without having had to successfully complete the Medical Council of Canada Evaluating Exam (MCCEE). All other Canadian jurisdictions required successful completion of the MCCEE as a prerequisite for licensure. Effective April 1, 2011 it will become a prerequisite in Saskatchewan as well (p. 6).

In July 2010, individual Colleges of Physicians and Surgeons across Canada adopted a common standard for license applicants. As a result, 13 different physician licensing systems

[68] Dr. Fleur-Ange Lefebvre is FMRAC Executive Director and Chief Executive Officer.

in Canada have effectively come to an end. The medical regulatory bodies have so far only set a common standard for a full licence to practise family medicine, but they plan to use that model for specialists as well. FMRAC decided to start with family medicine for two reasons. First, as Dr. Bryan Ward[69] writes, "frankly, the vast majority of international medical graduates will end up in family medicine, not in a specialty" (cited in Sylvain, 2010). Second, the new standard for family medicine can serve as a model for the more complicated work of defining standards for specialty practice. As Dr. Ward continues, adopting common standards "has required considerable effort in some of the cases of some of the provinces" (cited in Sylvain, 2010).

Achieving national compliance with the licensure standards implicit in the FMRAC Agreement calls for some change in policy and practices in every jurisdiction. Managing this change process will require strong leadership on the part of each College of Physician and Surgeons. Furthermore, it will also require the support of all provincial governments (Kendel, n.d.). If, in the end, medical regulatory authorities across Canada do implement the national standard for physician registration and licensure, it will not only provide physicians in Canada with a fairer and more transparent licensing process, but it will also ensure a more effective integration of IMGs into Canada´s health care system.

5. Conclusion

Labour mobility of physicians is an area where it is difficult to achieve consensus because of the independence of provincial medical regulatory bodies (Canadian Chamber of Commerce, 1998, p. 11). The revised AIT Labour Mobility Chapter constituted a positive step towards freer mobility of physicians across provincial borders. However, the consensus-driven approach applied to individual cases became one of its weaknesses as the failure of any one government to avoid favoring its special interests undermined the legitimacy of all

[69] Bryan Ward is a President of the FMRAC and a Deputy Registrar of the College of Physicians and Surgeons of Alberta.

(CGA of Canada, 2001, p. 15 – 16). The commitment of every government to abide by the principles and process of the AIT had to be unequivocal.

On the other hand, if governments took the position that any jurisdictional standard was acceptable, labour mobility would then become based on the least rigorous entry to practice standard rather than a commonly held standard among regulators (CPA, n.d., p. 2). As Dr. Bryan Ward (2009) stated, if the medical regulatory bodies did not agree on a common national standard and unfettered mobility was actually permitted, physicians currently not mobile would leave the remote and rural areas and move "into communities where there are no systems to monitor their practice as there might have been in the jurisdiction where they are registered" (cited in Silversides, 2009).

Consequently, to make licensure easier and ensure better public protection, provincial Colleges of Physicians and Surgeons adopted a common national standard for licensure. Highly-skilled foreign-trained doctors with restricted and provisional licences especially applauded this step because, if the common standard gets implemented, they would be able to move to another province and start practicing immediately. Before, IMGs who had only restricted or provisional licences usually experienced difficulties when they wanted to move to another province as the destination province might have not had the same type of restricted licences. Or, even if an IMG held a full licence in one jurisdiction and moved to another one, his/her credentials could have been assessed by different criteria and he/she might have got only a restricted licence or no licence at all (Sylvain, 2010).

The new national regime is almost locked in. As Dr. Ward said, all registrars, including the College of Physicians and Surgeons of New Brunswick, were at the table when the national standard was agreed upon (Sylvain, 2010). While the results coming with this new system are to be seen in the near future, it is likely that if it is successfully implemented,

IMGs will be able to integrate into the Canadian health care system more efficiently and quickly.

Chapter 5

Physician Mobility in the European Union

1. Introduction

Globalization has put pressure not only on eliminating labour mobility barriers in Canada, but also on reducing labour mobility barriers in Europe. The migration of skilled workers has always been an important element of the globalising economy. In a number of the European Union (EU) countries, immigration of skilled workers has become more important over time. The share of people with tertiary education is higher for the foreign-born (23%) than for the native-born (19.1%)[70] (OECD, 2008, p. 78). This phenomenon is partly attributed to increasing education rates across the globe and relative youth of the migration population, but it is also connected to policies adopted by industrialised countries to attract skills. Points systems, such as those in the UK or Canada, prioritise those with high level of education and experience[71] (Collett & Fuller, 2009, p. 3). In the near future, immigration of skilled workers will not just be a policy preference, but a very real necessity (Collett & Fuller, 2009, p. 3). Taking into account predictions about demographic decline, scarcity of skilled workers, low fertility rates, and population ageing in the upcoming years, the EU has been constantly working on a development of more transparent and harmonized rules for economic immigrants (Hoßmann et. al, 2008, p. 3).

[70] The only exceptions are the UK, Ireland, and Portugal where the difference in shares between the tertiary-education who are foreign-born and native-born amounts to more than ten percent. On the contrary, countries such as Germany and Finland have higher share of the tertiary-educated among the native-born than among the foreign-born (OECD, 2008, p. 78).

[71] In Canada, for instance, the percentage of foreign-born having tertiary education is higher than the percentage of native-born. While 62% of immigrants coming to Canada have some post-secondary education , only 49% of native-born do (Bergeron, 2009, p. 26 – 27).

Comparing the fairly new, still emerging, political structure of the EU and the already well-established federal union might appear to prejudge the question whether the EU has already developed into a federation. However, this chapter does not come to any such conclusion. Rather, it seeks to identify what labour mobility provisions were adopted by the EU member states and what negotiations preceded those provisions. Making comparisons between Canada and the EU makes sense because both are multilevel systems of governance, which face strong centre-periphery or autonomist tendencies. Furthermore, as it was pointed out by Armand de Mestral[72] and Jan Winter[73] (2001),

> The EU is more properly compared with a federation, that is, a political entity, than with a free trade association. The presence of supranational law-making institutions and supreme law having direct effect on the citizens of each Member State, combined with the broad jurisdiction conferred upon the EC, have created a quantum difference between the EU and many free trade associations that exist throughout the world today (p. 982).

The main purpose of this chapter is to investigate the barriers to mobility of skilled professionals across the EU, and what steps have been taken to remove them. To narrow the scope of this chapter to a manageable level, the main focus is put on the mobility of health care professionals and recognition of their qualifications across the EU-27. Findings from this chapter also help address the question whether the EU model has any practical applicability for Canada at the moment.

2. Rights of EU Citizens (Workers)

European law has had a significant impact on medical practice in the EU. The existing body of EU law in this area (the Community acquis) has provided all EU citizens with the

[72] Armand de Mestral is a Professor of EC Law at McGill University.
[73] Jan Winter is a Professor of EU Law at Free University at Amsterdam.

right to move freely within the EU for work purposes (Europa, 2010a). EU law on free movement of workers, including the Treaty provisions, secondary legislation, and rulings of the European Court of Justice (ECJ), has especially been focused on ensuring that there are no measures imposing restrictions on the freedom of movement (Hervey & McHale, 2004, p. 199). This section introduces some of the most important provisions established by the EU primary and secondary legislation concerning mobility of workers, particularly physicians.

2.1. Freedom of Movement in the Primary Legislation

The history of institutionalized labour mobility in Europe started with the Treaty of Paris of 1951—the founding treaty of the European Coal and Steel Community (ECSC), which had the goal to give all European citizens the right to work and settle in any EU member country. However, because this provision was economically motivated, it was limited to only some industrial sectors (Thunnissen, 2010, p. 21). That changed in 1957 when the Treaty of Rome established the European Economic Community (EEC). Article 3c of that Treaty specifically urged all member states to eliminate obstacles to free movement of persons and services (European Commission, 1957). Furthermore, the Treaty of Rome also institutionalized the free movement of *all* workers within the EEC, as most explicitly expressed in Articles 48 – 51. These articles not only abolished any discrimination based on nationality between workers of the EEC member states, but they also gave the EEC workers rights to look for a job in other countries; to work there without a work permit; to stay there for that purpose; to live there even when the job has finished; and enjoy equal treatment as nationals regarding the access to employment and working conditions [74] (European Commission, 1957; European Commission, n.d.,a).

[74] Article 48 EEC Treaty applied to both nationals who left one EU country to work in another EU country, and to nationals who returned to their home country. A worker has been defined as a person who (1) undertook genuine and effective work, (2) under the instructions of somebody else, (3) for which he/she was paid. Self-employed persons, students, retired or economically non-active persons were not covered by Article 48 EEC but by other provisions of Community law (European Commission, n.d.).

Over time, a move towards the free movement of all EU citizens, not only economically active persons, was advocated. It followed that when the Treaty on European Union (Maastricht Treaty) of 1992 entered into force, the right "to move and reside freely within the territory of the Member States" transferred to "every citizen of the Union" (Eur-Lex, 1992, Article 8a). However, neither the Maastricht Treaty, nor the following EU treaties—the Treaty of Amsterdam of 1997, the Treaty of Nice of 2001, and the Lisbon Treaty of 2007—changed much with regard to the free movement of workers. Therefore, additional legislative acts, examined in the next sub-section, were necessary to bridge the gap.

2.2. Mutual Recognition of Physician Qualifications in Secondary Legislation

Mutual recognition of qualifications among the EU member states has always been crucial to accomplishing free movement of workers. This fact is explicitly cited in Article 57(1) of the Treaty of Rome (European Commission, 1957). Based on that article, the European Commission and the European Council introduced a few directives[75] with the aim of completing the European Single Market (Blitz, 1999, p. 314 - 315). And although there is no such a thing as a "European health law", the EU law has become increasingly involved in the health care sector of states (Hervey & McHale, 2004, p. 4).

The EEC first legislated with regard to physicians in June 1975. Two Directives, 75/362/EEC and 75/363/EEC, adopted by the European Council significantly facilitated the free movement of doctors (Eur-Lex, 1975a; Eur-Lex, 1975b). The first Directive, 75/362/EEC, specified the diplomas acceptable for medical practice in other EU member states (Eur-lex, 1975a, Article 3), as well as the specialist diplomas and titles of medical specialties recognized in other member states (Article 5), or at least in two or more of them (Eur-lex, 1975a, Article 7). The second Directive, 75/363/EEC, urged all member states to

[75] See Glossary.

require persons wishing to enter the medical profession to hold a diploma or other evidence of formal qualifications in medicine, referred to in Article 3 of Directive 75/362/EEC. All member states had to ensure that during the training period the person concerned acquired adequate knowledge and experience related to medical sciences (Eur-lex, 1975b, Article 1.1), and underwent "at least a six-year course or 5 500 hours of theoretical and practical instruction in or under the supervision of a university" (Eur-lex, 1975b, Article 1.2).

At that time, the Community relied only on directives harmonizing[76] medical training requirements. Therefore, in December 1988, the European Council introduced a general Directive 89/48/EEC[77] on the recognition of higher-education diplomas awarded on the completion of professional education and training of at least three-year duration. The aim of the Directive was to enable holders of the higher-education professional diploma in one state to be recognized – without prior harmonization of training – in other member states regulating that profession (Eur-lex, 1989). Since Directive 89/48/EEC was adopted to establish a general system[78] for recognition of diplomas, and doctors were already covered by a sectoral system[79], Directive 89/48/EEC was not supposed to apply to them. However, the ECJ ruled in C-39/07 that Directive 89/48/EEC could not be precluded from being applied to medical professions as well (Eur-Lex, n.d.).

In 1993 all medical directives adopted since 1975 were consolidated into a one Sectoral Directive 93/16/EEC, which facilitated the free movement of doctors by automatic recognition of certificates, diplomas, and other formal qualifications (Eur-lex, 1993; Europa, 2007). One of the most recent directives concerning the mutual recognition of professional qualifications—Directive 2005/36/EC—set out three different mechanisms for recognition of

[76] See Glossary.
[77] This Directive was later supplemented by two other Directives—92/51/EEC and 99/42/EC (European Commission, 2010a).
[78] See Glossary.
[79] See Glossary.

qualifications[80]. Physicians, together with six other sectoral professions[81], fell into the category of automatic recognition of qualifications where training and conditions were harmonized (European Commission, 2010b).

2.3. How Does the System Work in Practice?

To become eligible for medical practice in any EU host country, physicians must apply to a national authority of the host country, providing a proof of their qualifications. That authority must acknowledge their application within one month, assess it, and decide whether to grant the application within three months[82]. If the host nation national regulatory body decides to recognize the physician´s qualifications, the physician becomes automatically able to use his/her professional title (European Commission, 2011a).

If, on the other hand, the national regulatory body does not recognize physician´s qualifications, he/she can appeal to a court (European Commission, 2011a). The ECJ particularly can declare a member state to be in breach of its obligations, either as a result of incorrect application of EU law or as a result of incompatibility of national legislation with EU law. It is then up to the competent authority of that member state to amend its decision and comply with the Court´s ruling (RICS, 2010, p. 3 – 4). Apart from the ECJ, EU citizens can turn to an informal dispute resolution mechanism called SOLVIT. It is an on-line problem solving network, which deals with the misapplication of internal market rules without legal proceedings and is funded by the European Commission. SOLVIT Centres are established in every EU member state (as well as in Norway, Iceland, and Liechtenstein) and their use is free of charge. When a problem arises, two SOLVIT Centres—the "Home"

[80] The three mechanisms include (1) a sectoral system for recognition of professional qualifications, (2) a general system for recognition of professional qualifications, and (3) a system based on recognition of professional experience. Concerning the third system, professionals who work in the craft or commerce sectors or industry have two possibilities as to how to get their qualifications recognized: they can either request automatic recognition on the basis of professional experience or they may request recognition for their qualifications on the basis of a general system. (European Commission, 2011b; ACE, n.d.).

[81] Doctors, dentists, pharmacists, veterinary surgeons, midwives, nurses, and architects (European Commission, 2010b).

[82] In some complicated cases the process might take up to four months (European Commission, 2011a).

SOLVIT Centre[83] and the "Lead" SOLVIT Centre[84]—work together to provide a resolution within ten weeks[85]. And although the proposed solution is not binding, using SOLVIT does not bar legal action through a national court later if a problem goes unresolved or the proposed solution is considered unacceptable (European Commission, n.d.,b).

To enhance the cooperation of member state administrations involved in the foreign credential recognition process, the European Commission together with the EU member states also developed a secure internet application—the "Internal Market Information System" (IMI)[86]. IMI helps overcome practical obstacles to communication, such as different languages, different administrative structures, lack of administrative procedures for cross-border cooperation, and management of 351 bilateral relationships in the EU (Europa, 2009; European Commission, 2010e, p. 6). It is a strong network of more than 5700 authorities, and more authorities are continuously getting involved. Sixty percent of requests dealing with professional qualifications are replied to within two weeks (European Commission, 2010c, p. 7, 23; European Commission, 2010f, p. 1 - 6).

The EU states have definitely benefited from the improved technology. Recognition of professional qualifications has been made easier, faster, and more effective. Based on the EU member states´ statistics, more than 80% of demands for recognition lead to a positive decision with no need for compensatory measures (European Commission, 2005, p. 2).

3. Negotiating Process

The EU is not a federation, nor is it just an organization for cooperation between national governments. The EU is, in fact, unique. The EU member states remain independent

[83] This Centre is located in the person´s home country.
[84] This Centre is located in a member state where the problem has arisen.
[85] Since SOLVIT is an informal dispute resolution, its use is quicker than making a formal complaint (European Commission, n.d.b).
[86] The internal market legislation that IMI supports is the Professional Qualifications Directive (2005/36/EC) and the Services Directive (2006/123/EC) (European Commission, 2010d).

sovereign countries but they delegate some of their decision-making powers to common institutions they have created so that certain matters of joint interest can be made at European level (Europa, n.d.). This section first explains the importance of tripartite cooperation—involving professional regulatory organizations, national governments, and the EU institutions—characteristic of regulation of medical professions in the EU member states. Second, it examines the negotiating process leading to a harmonization of minimum training requirements and automatic recognition of physician qualifications within the EU.

3.1. Tripartite Cooperation in the Regulation of a Medical Profession

The medical profession is identified by reference to special regulatory controls imposed on those practicing that profession. Such regulation is justified by the nature of the job because the regulators are in the best position to judge their peers (Friedson, 1988, p. 25). As Tamara K. Hervey[87] and Jean V. McHale[88] (2004) point out, there exists a "regulatory contract" between the profession and the state—a mix of self-regulations through professional regulatory organizations and state regulations. Thus, the provisions regulating health care differ in many respects from one state to another (p. 190). National control over health care professionals derives primarily from the desire to protect patients; therefore, the ECJ has continually ruled that EU law "does not detract from the powers of the Member States to organize their social security systems", including their national health care systems (Hervey & McHale, 2004, p. 194).

This arrangement has created a very important context for the EU-level rules concerning physicians. The European Commission had to cooperate closely not only with the national governments, but also with the member states´ professional groups and organizations to establish and refine the process of qualifications recognition. Involving all levels of

[87] Tamara Hervey is a Professor of EU Law at the University of Nottingham, UK.
[88] Jean McHale is a Professor of Law at the University of Leicester, UK.

competent authorities has significantly helped overcome one of the major barriers to free movement of physicians—a low degree of mutual trust between member states with respect to their standards of medical education and training (European Commission, 2005, p. 3 – 4).

3.2. The First Negotiations and the First Doctors Directives

Even though the Treaty of Rome of 1957 contained provisions regarding the free movement of workers, EU member states were not obliged to recognize professional qualifications in other member states, and often did not. This represented a huge barrier to the freedom of movement of professionals and led to a development of processes that would facilitate recognition of education, training, and qualifications required in another EU country (Keigley, 2009, p. 1).

In 1958, medical specialists from then six EEC member states created the European Union of Medical Specialists (UEMS). In 1962, the UEMS formed Specialist Sections so that comparable criteria and levels of training in member states could be established. These sections, working together with the Standing Committee of European Doctors (CPME)[89], have regularly provided advice and expert opinion for the European Commission[90]. Composed of the EU member states´ National Medical Associations, the CMPE has often acted as an "umbrella organization" for the whole profession in Europe[91] (BMA, 2011, p. 7). Its main goal has always been both "to promote the highest standard of medical training and medical practice" in Europe and to advance the free movement of doctors within the EU (CPME, n.d.,a).

[89] CPME (Comité Permanent des Médicins Européens) is an international non-profit medical association that was established in 1956 (BMA, 2009, p. 7; CPME, n.d.a).
[90] Although national governments (via the Council of Ministers) and the European Parliament are the ultimate legislators, the European Commission makes policy in the health area. Responsibility for professional qualifications lies with the Internal Market Directorate-General (Sallie, 2004, p. 87).
[91] The CMPE is currently composed of 27 members; thereby representing all medical doctors within the EU (CPME, n.d.b).

To achieve these goals, the CPME Specialist Sections have closely cooperated with the EU institutions, which led to an introduction of a majority of the coordination and harmonization concepts for specialist training and also the criteria for recognition of specialist credentials (CPME, n.d.,a; Lange, 2001, p. 561). The European Commission thus accepted talks with the CPME, recognizing the value of information and suggestions from such a body and its importance in representing physicians in the EU member states. Other European bodies representing specific areas of medical practice, such as the European Union of General Practitioners (UEMO)[92], Permanent Working Group of European Junior Doctors (PWG)[93], European Association of Senior Hospital Physicians (AEMH)[94], and the European Federation of Salaried Doctors (FEMS)[95], became the CPME´s observers and appointed liaison officers to the CPME (Rowe, 2010, p. 15).

In spite of the initial optimism in the EU, progress was very slow and painful (Michelmann, 1979, p. 207). By 1973, Ralf Dahrendorf [96] saw that there were still fundamental problems regarding physician mobility, and that faster progress in this area was needed (Rowe, 2010, p. 15). Since the beginning of physician mobility discussions, the European professional groups worried about being asked by the EU representatives to change their individual systems of educational and training requirements to a standardized European version (Stallknecht, 1992, p. 561). European senior officials spent years devising the medical education and training requirements from scratch in order to make them more

[92] The UEMO was established in 1967 to represent general practitioners in the EU (its members are medical associations). The UEMO´s primary objectives have been (1) to promote the highest standards of medical training and practice, (2) to defend the role of GPs in health care system, (3) to promote economic, professional, scientific, and social interests of GPs and (4) to protect their freedom to practice (BMA, 2009, p. 8).

[93] The PWG was established in 1976 (1) to represent interests of junior doctors in Europe, (2) to formulate common views on relevant matters such as medical education, (3) to enhance relations between junior doctors in European countries, and (4) to protect standards of health care in Europe (PWG, 1976, Article 1.2).

[94] AEMH was established in 1963 to improve all aspects of hospital life in Europe. It is a professional association of European hospital physicians, which through its various working groups defends the interests of specific categories of hospital physicians (National Medical Associations in Europe, 2009).

[95] FEMS was established in 1964 to defend the interests of salaried doctors and to improve their working conditions. (FEMS, 2006).

[96] Ralf Dahrendorf was the EEC Commissioner responsible for External Relations and Trade.

comparable, “like pure beer, or rather tasteless Euro beer”. Officials counted the number of hours medical students had to spend on studying and training to lay down a norm on the basis of the count (Dahrendorf, 1984, p. 179). However, the diversity in organization and content of the basic medical educational and training programs proved to be a major impediment to the European officials´ plan (Michelmann, 1979, p. 208). Countries would have had to make profound changes in their educational systems to lay down a common norm, which they had been rather reluctant to do (Dahrendorf, 1984, p. 179).

Consequently, Dahrendorf decided to find a different way of facilitating the foreign credential recognition process in Europe. Thereupon, the famous “Dahrendorf Hearing” was convened in October 1973. The meeting was attended not only by representatives from the old six[97] and the three new[98] acceding countries, including representatives of the national governments, but also the EEC institutions, universities, health professions, consumer organizations, and other bodies (Rowe, 2010, p. 15 – 16). As a result of the Hearing, a new approach arose—establishment of European minimal medical education and training standards—substituting for the anticipated and feared standardization across the EU.

The new approach compelled the professional organizations and associations representing health professionals to reassess their attitudes. In spite of that, their main concern remained the same—protection of their own interests rather than advancement of the EC unity. Furthermore, every country continued to believe that its health care system was the best (Stallknecht, 1992, p. 561). Especially in the early and middle phases of the CPME´s existence, there were numerous occasions where significant differences of opinion between national delegations and even within delegations appeared (Rowe, 2010, p. 18). Although the path of least resistance was chosen—no member state had to revise its standards upward—it was not until 1975, after 16 years of discussions, drafts and redrafts of proposals from the

[97] Belgium, France, Germany, Italy, Luxembourg, and the Netherlands.
[98] Denmark, Ireland, and the UK.

European Commission, that the EU member states agreed on the adoption of directives that would constitute a platform for mutual recognition of medical diplomas (Michelmann, 1979, p. 207, 210; Rowe, 2010, p. 16).

To provide informed agreed advice to the European Commission, doctors from the Specialist Sections suggested that the European Commission establish an Advisory Committee on Medical Training (ACMT) (Crisp, 1990, p. 629). Citing the Council´s earlier Resolution of 1974[99], Decision 75/364/EEC, Article 2.1 stated that the ACMT´s main task was to "help ensure a comparably demanding standard of medical training in the Community, with regard to both basic training and further training". The ACMT, established in the following year, became an official body of the EU with the charge to achieve such a goal. Specialist sections were supposed to inform the ACMT via the UEMS Executive Committee and the CPME (Lange, 2001, p. 561), and the ACMT then was to communicate its suggestions and opinions to the European Commission and the EU member states (Eur-Lex, 1975c, Article 2.3). However, since every harmonization could ultimately lower some of the medical standards, "high-standard" countries watched the ACMT´s activity with anxiety (Michelmann, 1979, p. 217).

The final, revised, version of Doctors´ Directive differed a great deal from the initial expectations associated with earlier propositions: a common training program for all member states was not accepted; every member state could make its programs as rigorous as it desired (as long as the programs complied with the directives´ very broad guidelines); no differences between the EU member states in terms of medical education or training were removed through a standard upgrading; member state officials retained their full authority over medical education and training programs; and the power of EU institutions did not increase (Michelmann, 1979, p. 212, 218). Clearly, the desire of member state authorities to remain

[99] Council Resolution on the mutual recognition of diplomas, certificates and other evidence of formal qualifications (Eur-Lex, 1974).

autonomous within their own borders was stronger than their desire to establish deeper integration in the medical policy area.

3.3. Years of Uncertainty: 1976 – 1992

The ACMT first met in 1976 and over the next nine years established a pattern of hard and intense work, producing a number of reports and recommendations relating to the first two Doctors´ Directives. The ACMT recommendations have mostly served as a basis for development of medical training within the individual member states. In fact, as Hans Karle[100] and Thomas Kennedy[101] (1989) stated, the ACMT could be said "to provide an additional channel for national negotiators having difficulty achieving reform goals of a modern international standard" (p. 404).

Although using only indirect influence, the ACMT has significantly contributed to a reduction of traditional differences between Northern and Southern Europe and improved the quality of medical education (Wojtczak & Schwartz, 2006). Between 1976 and 1985, the ACMT met frequently to draft reports and debate in plenum. Yet, because of financial difficulties in 1985, meetings of the ACMT began to be postponed or even cancelled, the ACMT lacked support and resources, and its recommendations were often ignored (Sallie, 2004, p. 86).

Furthermore, due to the diverging interests of the EU member states, introduction and implementation of sectoral directives proved administratively burdensome. Regulations turned out to be difficult to arrive at and mutual recognition of medical credentials in the 1980s made little headway. Therefore, in 1985 the European institutions shifted their policies and decided not to introduce any new sectoral directives (Gerlinger & Schmucker, 2007, p. 185). The only sectoral directive introduced after that was Directive 93/16/EC which,

[100] Hans Karle is currently the President of the World Federation for Medical Education in Denmark. He has served as a member of several Boards and Medical Societies.
[101] Dr. Thomas E. Kennedy is a certified doctor in internal medicine and neurology.

however, only consolidated versions of the older Doctors´ Directives 75/362/EEC, 75/363/EEC, and 86/457/EEC.

3.4. New Vision: 1993 – Present

Directive 93/16/EEC was due for a review in 1995. Therefore, the UEMO organized a Consensus Conference on Vocational Training in general medical practice in 1994. From this Conference developed a series of recommendations, which not only gained wide support in the CPME, but also created the basis for a report[102] of the ACMT to the European Commission in 1996 (CPME, 1998, p. 2; EURACT, n.d.). The main question was whether to keep the sectoral system at all or replace it by a more general system. The Commission formed a group of representatives from various medical professions and national governments, and launched an extensive debate regarding the future of sectoral directives and their advisory committees[103]. Both groups advocated keeping both[104]. The general system was believed to be less attractive and the professional bodies with experience of running both preferred the sectoral one (Sallie, 2004, p. 86).

With the envisioned enlargement of the EU in 2004, the European Commission, however, kept looking for a simpler and cheaper system for recognizing professional qualifications. In 2001, it published a working paper on the future regime for professional recognition, hinting strongly at its desire to replace the current sectoral regime (Europa, 2001). The main objectives of the Commission´s initiatives were:

[102] Report and Recommendations on the Review of Specific Training in General Medical Practice: Advisory Committee on Medical Training (to the European Commission), XV/E/8433/95-EN October 1995.

[103] Among the EU health professionals, there has always been a consensus that the advisory committees are one of the most important elements in terms of implementing sectoral directives. They have been perceived to provide quality assurance without which the system would not have any safety guarantees. This view has been expressed repeatedly in national and pan-European submissions to the European Commission (Sallie, 2004, p. 88).

[104] The only exception was the UK where there was an intense debate with the medical profession, with dissent in some quarters. Nevertheless, the final decision of the UK Department of Health maintained that although the sectoral system was flawed, it was "the lesser of two evils" and thus should be retained (Sallie, 2004, p. 86).

- to simplify and consolidate the existing rules and procedures (…), thereby guaranteeing more transparency and legal certainty;
- to introduce greater flexibility into the system to allow more possibilities for automatic recognition between Member States;
- to further liberalise the free provision of services through simplified procedures in line with the Internal Market Strategy for Services (EFCA, 2001, p. 7).

In June 2001, the European Commission launched a broad consultation to prepare for a new directive on mutual recognition of professional qualifications. By September 2001, a total of 302 responses were received from the EU member states and professional organizations (at both EU- and national-level). Most professions covered by the sectoral system[105] emphasized again the advantages of automatic recognition provided by the sectoral directives. All respondents opposed the replacement of sectoral directives and urged the European Commission to preserve the benefits of automatic recognition (European Commission, 2002, p. 1 – 2, 8 – 12). Underlying all the debates was a tension between the free movement of professionals—the Commission´s top priority—and the need to guarantee quality and ensure patient safety—the professional organizations´ top priority (Sallie, 2004, p. 87). As pointed out by Bland Duncan (2002) in the British Medical Association Weekly Newssheet, it is unusual for European citizens to advocate for greater interference and regulation and a European institution to try to avoid providing it (paraphrased in Sallie, 2004, p. 87).

In July 2002, the Commission published a legislative proposal based on the results of the consultation. According to the proposal, fifteen existing directives[106] were to be brought together under one directive to clarify and simplify the rules on free movement of

[105] Only veterinarians stated that the sectoral system does not provide sufficient guarantees of quality standards (European Commission, 2002, p. 2).

[106] The fifteen directives, affecting more than 800 different professions regulated by member states across the EU, included: three general system Directives—89/48/EEC, 92/51/EEC, and 99/42/EC—and twelve sectoral Directives applying to doctors, general nurses, dental practitioners, veterinary surgeons, midwives, pharmacists, and architects (Eur-Lex, 2004; European Commission, 2009, p. 3).

professionals between the EU member states (Europa, 2004). The Commission´s proposal was approved by the European Parliament in 2004[107] and was then followed by the Council´s political agreement by qualified majority[108] as opposed to unanimity (with Germany and Greece voting against). Speaking after the Council´s approval, Commissioner Bolkestein stated,

> Persuading Member States to get rid of barriers within the Internal Market is a bit like pulling teeth – it´s bloody business and painful. In the end, the result is there. In some respects, it is disappointing but it is acceptable (Todd & Fabbi & Sandler, 2004).

Although sectoral systems for medical professions remained in place, a specific directive for doctors ceased to exist[109] (UEMS, n.d.). However, the European Commission did not get its way totally. Professional organizations were able to mobilize such concerted lobbying that automatic recognition of professional qualifications was retained (Royal College of Nursing, 2011, p. 2). European Directive 2005/36/EC was adopted on 7 September 2005[110]. The deadline for its transposition into domestic laws was set on October 2007 (Ling, 2007, p. 4); however none of the member states met the October 2007 deadline (European Parliament, 2009a). As a result, the Commission initiated infringement proceedings against all EU member states. It was not until a further action undertaken by the European Commission and the ECJ that the member states finalised the Directive transposition (European Commission, 2010g, p. 6)[111]. As Malcolm Harbour[112] noted, when

[107] Although approved, the members of the European Parliament radically altered the Commission´s proposal—over 100 amendments were adopted (UK Office of the European Parliament, 2004).
[108] See Glossary
[109] The sectoral and general directives were merged together to make the legislation simpler and more transparent.
[110] Directive 2005/36/EC was later amended by Directive 2006/100/EC because of the accession of Bulgaria and Romania.
[111] Bulgaria (February 2008), Finland (November 2008), Italy (November 2007), Malta (January 2008), Romania (February 2008), and Slovakia (June 2008) completed the Directive transposition after they received

addressing the transposition of Directive 2005/36/EC, "[i]t has taken much longer than people expected to bring this into operation, and that of itself raises concerns about the complexity of the instrument itself" (European Parliament, 2009b).

4. Conclusion

Tension between the free movement of EU professionals, allowing them to practice in host member states, and the regulators´ concerns about standards and patient safety have surfaced on many occasions since the 1970s. The Internal Market Directorate of the European Commission has been charged with overseeing the EU legislation and taking infringement proceedings against any member state that does not comply with it. EU legislation has always been binding on EU member states and paramount to the national legislation (Royal College of Nursing, 2011, p. 2). Recognition of doctors´ qualifications across Europe has been regulated at the European level since the 1970s, and Europeans were the first to systematically apply mutual recognition of qualifications to professions. Consequently, their historical experience is worth drawing lessons from because it demonstrates alternative approaches to recognition of professional qualifications and provides a roadmap for other countries (Nicolaïdis, 1997).

One of the major difficulties in drawing lessons from the EU is that it is not a finished concept. However, Canada is also work in progress and as such is unlikely to remain static. As pointed out by Armand de Mestral and Jan Winter (2001), "however complex and tightly drafted the federal constitution may be, it is no assurance against the forces of change, which

---

letters of formal notice. The Czech Republic (October 2008), Denmark (November 2008), Estonia (December 2008), Latvia (November 2008), Lithuania (April 2008), Netherlands (February 2009), Poland (November 2008), and Slovenia (July 2008) completed the Directive transposition after they received reasoned opinions. Cyprus (April, 2010), Hungary (September 2009), Ireland (April 2009), Portugal (March 2009), Spain (January 2009), and Sweden (June 2009) completed the Directive transposition after a legal action before the ECJ. Austria (September 2010), Belgium (May 2010), France (May 2010), Germany (March 2010), Greece (May 2010), Luxembourg (September 2010), and the United Kingdom (January 2010) completed the Directive transposition after the ECJ decisions (European Commission, 2010g, p. 6, 18 – 21).

[112] Malcolm Harbour is a member of the European Conservatives and Reformists Group in the European Parliament, and the Chairman of the Committee on Internal Market and Consumer Protection.

are in fact central to healthy federation (…); change is inevitable and generally desirable" (p. 982).

With regard to mobility rights, mobility of professionals in Canada has been seen as a right of citizenship linked to both personal rights in the sense of a human rights, and economic efficiency. In spite of that, provincial jurisdictions over professional activities have often posed problems for citizens wishing to move from one province to another to pursue their profession. Within the EU, on the other hand, mobility has always been primarily a right exercised by employees and employers to seek and give work (De Mestral & Winter, 2001, p. 979). In spite of that, the European Community has authority to harmonize national laws of the member states (De Mestral & Winter, 2001, p. 1008), which is different from Canada where no federal or single government agency exercises authority over provincial laws. As a result, the EU often protects mobility rights of professionals more effectively than it is the case under the Constitution in Canada.

Far-reaching harmonization of medical education and training with a view of promoting greater mobility of professionals has now been accepted by European professional organizations for more than half a century. Countless person hours of committee work and many air miles have been devoted to its promotion (Bearley, 2005, p. 297) simply because automatic recognition of professional qualifications has been perceived as the best instrument for achieving efficient and effective free movement of professionals within the European single market. It has been argued that unless there is an absolute freedom to practice professions anywhere in the world, professionals, including physicians, will not be able to respond to the global needs (Enemark & Plimmer, 2002, p. 7). Furthermore, establishment of a pan-European labour market with no barriers to professionals´ mobility has become a high priority for all European institutions that share the belief that problems related to ageing of

populations and increasing demand for health care professionals in many developed countries could be addressed through increased physician migration (Shah & Long, 2007, p. 4).

The EU has developed a number of instruments to facilitate physician migration and recognition of their qualifications. Among the most prominent are SOLVIT and the IMI system. SOLVIT services help resolve problems encountered by citizens and businesses caused by a misapplication of Internal Market law. If SOLVIT services prove to be insufficient, citizens can still make an appeal to their national court or to the ECJ. EU citizens thus have access to various instruments in case administration in another member state does not recognize their qualifications. Such services should be made available to professionals in Canada as well.

The IMI system, on the other hand, was developed primarily for the member states, not for the citizens. This electronic tool facilitates day-to-day cooperation and communication between relevant national authorities and enables appropriate regulation of service providers operating across borders. It allows competent authorities to be easily identified and also to send/receive requests for information about professionals (BIS, n.d.). The idea of a Europe-wide network is a great one. In Canada, there could be 13 provincial centres with a uniform goal of providing information about physicians. Having only one contact point rather than all sorts of sources in the host province would make it significantly easier for regulatory organizations to obtain information about physicians in question. Again, having such a tool in Canada would definitely increase the speed and efficiency of credential recognition.

It will be interesting to watch what provisions or mechanisms for physicians trained in third countries the EU develops. At the moment, physicians who are not citizens of EU countries have no rights guaranteed by EU treaties or directives to automatic recognition of their qualifications. Although they can apply for an individual assessment, they typically have to pass other tests and undergo additional training to obtain a full licence to practise in the

EU. Extending recognition of professional qualifications to third country nationals will be a challenge for the EU member states (Beek, 2007, p. 2; Rytz, Sylvest, & Pedersen, 2009, p. 8). However, if true physician mobility is to be in effect, automatic recognition of qualifications needs to be extended to all IMGs. It remains to be seen how resistant national sovereignty will be to contemplating additional country partners and what political forces will be mobilized to fight back.

Chapter 6

Results and Conclusions

1. Introduction

The final chapter is concerned with the findings. Because there were three separate groups of research questions in the beginning, this chapter is divided into three sections as well, each of them addressing one group of questions. The first section is based almost entirely on the data received from interviews and draws a comprehensive picture of the medical regulatory organizations´ role in recognizing IMGs´ credentials. The second section uses information collected from both interviews and official websites of Colleges of Physicians and Surgeons across Canada to clarify the ambiguity about inter-jurisdictional barriers to labour mobility. Lastly, the third section provides a bigger perspective on recognition of foreign qualifications by looking at the EU model and assessing whether the EU can serve as a model for Canada with regard to credential recognition and labour mobility issues.

2. Research Question One

As noted above, the first section of this chapter presents an answer to the research question why recognition of foreign medical credentials by medical regulatory organizations continues to constitute a barrier to IMGs´ medical practice in Canada. The underlying aim of the question was to find out whether the CPSS purposely restricts the entry of IMGs into a medical profession because of the SMA´s influence.

All interviewees agreed that the current structure of 13 separate regulatory bodies in Canada, called Colleges of Physicians and Surgeons, affects both recruitment and integration of internationally-trained physicians. Every physician pursuing a medical licence in Canada

has to first fulfill the occupational standards and certification requirements set by a province and enforced by its regulatory body. Consequently, a majority of IMGs often find that in order to obtain a licence to practise medicine in Canada, they have to repeat their post-graduate medical education.

Based on the information provided by Dr. Bowmer and Dr. Kendel it appears that the main reason for non-recognition of IMGs´ credentials is the change in countries where nowadays IMGs obtain their qualifications. Compared to the 1970s or 1980s, when most IMGs received their qualifications in the UK, Australia, New Zealand, South Africa, and Ireland, IMGs now come from a much wider array of countries, including especially countries in Asia, Eastern Europe, and the Middle East, where they receive their under-graduate and post-graduate education. The quality and consistency of post-graduate education in these countries is, however, far less known to the Canadian medical regulatory bodies.

As Dr. Kendel explained, physicians who have completed their undergraduate and post-graduate education in the US have been historically accorded preferential access to registration in Canada because Canada and the US share common accreditation programs for medical education. Also those IMGs who have completed their post-graduate training in the UK, Australia, New Zealand, South Africa, or Ireland have been given preferential eligibility for registration because the Canadian regulatory bodies have a good understanding of and confidence in the quality of post-graduate education in those countries. On the other hand, recognizing the equivalency of post-graduate training worldwide has proved to be immensely more challenging, mainly because the medical regulatory bodies do not have means to assess credentials of IMGs from countries other than the five mentioned above. The main fear of regulatory organizations is that IMGs from those countries might not have the ability to communicate effectively with both other physicians in the Canadian health care system and patients.

Another question posed in this section sought to find out whether the CPSS purposely restricts IMGs´ entry into medical practice at the SMA's request. Dr. Kendel rejected this view and argued that the CPSS does not have any obligation to pay more attention to the SMA´s views more than those of any other organization. He explained that the CPSS would accept the SMA´s recommendations only if it thought they made sense and were in the public interest. Dr. Vogel argued that the SMA does have an influence on the CPSS; it can provide suggestions to the CPSS, but it cannot tell the CPSS what to do. Dr. Marchildon confirmed those arguments and stated that the SMA does not have more than an indirect influence on the CPSS.

Consequently, the main finding of this section was that the barriers IMGs experience when they pursue a medical licence in Canada are neither caused by purposeful discrimination or unfair treatment by regulatory bodies, nor are they caused by unreasonably high occupational standards. The main barrier is the absence of appropriate tools for assessment of IMGs´ competency and credentials. Therefore, to improve the recruitment and integration of IMGs into the Canadian health care system, it is necessary to direct greater energy and resources towards the development of a common integrated system for assessment especially for those IMGs who obtained their credentials in countries where the medical education is unknown to the regulatory bodies.

Taking into account physician shortages in certain areas and the increasing diversity of the Canadian population, integration of unlicensed IMGs currently residing in Canada seems to be a reasonable solution (Crutcher et al., 2003). Fortunately, both the provincial governments and regulatory bodies have a clear understanding of the challenges IMGs face; therefore, there is room for optimism that they will eventually adopt a more accessible, efficient, and faster assessment system for all IMGs.

3. Research Question Two

The second group of research questions inquired what new provisions the revised AIT Labour Mobility Chapter introduced to reduce or completely eliminate the inter-jurisdictional barriers to health care professionals´ mobility across Canada and what other, alternative, approaches there might be to accomplishing full mobility of labour.

Under the revised AIT Labour Mobility Chapter the obligation placed on governments has become clear—to license any applicant who is already certified by a regulator in another jurisdiction. As Dr. Kendel noted, the AIT does not allow any form of additional testing once a physician is licensed in one jurisdiction. It only allows for certain conditions to be attached to a medical licence but it does not preclude full mobility of physicians. Dr. Bowmer further added that the only barrier could be a physician's not having a document attesting to the absence of a criminal record or a certificate of good professional conduct.

Nevertheless, jurisdictions with high occupational standards expressed their concerns that because of the new AIT obligation to mutually recognize all physicians coming from elsewhere in Canada (1) standards for physician licensure might fall to the lowest common denominator, (2) the responsibility of regulators to protect the public safety could be compromised, and (3) the ability of regulators to ensure that only qualified physicians provide competent care could eventually be negated (CPSA, n.d.). Therefore, regulators from the Colleges of Physicians and Surgeons across Canada started working together with the federal and provincial governments to resolve jurisdictional differences and negotiate a workable solution. Both Dr. Bowmer and Dr. Kendel confirmed that the current move is towards a single, national licensure standard. Dr. Kendel further argued that arriving at uniform licensure standards across Canada attained by collaborative work of all regulators through FMRAC is the most effective methodology for eliminating unnecessary inter-jurisdictional barriers to physicians´ mobility.

To conclude, the revised AIT Labour Mobility Chapter brought unexpected results. While it did not resolve different occupational standards and inconsistent regulatory frameworks from province to province (even though it did remove restrictions on labour mobility), it led to a far more comprehensive approach—development of national licensure standards based on minimum educational and training qualifications. This approach seems to be currently the most effective one for eliminating inter-jurisdictional barriers related to non-recognition of physicians´ qualifications.

4. Research Question Three

The third research question sought to find out how the EU reached a consensus on automatic recognition of physicians´ qualifications and what kind of negotiations preceded this consensus. The ultimate goal was to investigate whether Canada could learn any lessons from the EU experience with regard to recognition of physicians´ qualifications and physicians´ mobility.

In terms of mobility rights of physicians, the EU took a different path to achieving full labour mobility of physicians than Canada. However, the result turned out to be very similar—automatic recognition of physicians´ qualifications based on minimum education and training requirements. In the EU, any physician qualified for an occupation in one EU member state has to be recognized as qualified for that occupation in any other EU member state as well. As the CPME stated,

> Directive 2005/36/EC has made the migration of physicians in Europe substantially easier. Access to professional employment in other Member States of the European Union has been made considerably simpler by the minimum training requirements set out in Article 24 of the Directive. The medical profession provides a prime example of the advantages of automatic recognition (2011, p. 9).

However, negotiations that led to automatic recognition were rather cumbersome.

During the first phase (until the mid-1970s), far-reaching harmonization of professional training standards constituted a pre-requisite for mutual recognition of diplomas. On this basis, the European Commission together with the member state representatives set out training requirements which were to be respected in each member state, including quantitative requirements as to the minimum number of hours of courses and training (Nicolaïdis, 1997). A second approach followed in the mid-1970s, replacing the quantitative harmonization with qualitative harmonization as a foundation for mutual recognition. According to this paradigm, equivalence of diplomas was supposed to be predicated on their similarity (Nicolaïdis, 1997). Ultimately, establishment of medical minimum education and training requirements became the basis for automatic recognition of qualifications in the EU.

While the EU was the first to apply the principle of automatic recognition to medical professions, Canada has recently adopted this principle as well. If, in the end, the FMRAC Agreement on National Standard does get implemented, access to medical professions in Canada will be granted to Canadian applicants with the same ease as to the ones in the EU. Since the EU has been on this path for almost half a century now, Canada should examine the EU experience and ensure (1) that it does not make the same mistakes as the EU did, (2) that all stakeholders cooperate, and (3) that it develops the mechanisms that proved to facilitate the process of automatic recognition in the EU.

In terms of the first point, as was demonstrated, implementation of EU directives posed many challenges and often required involvement even of the ECJ. Lack of trust of other member states´ education and training systems was the primary reason for a non-uniform application of EU directives across the member states and the delays in their implementation. Consequently, provincial governments should collaboratively establish appropriate

enforcement mechanisms, such as infringement proceedings and/or sanctions, to ensure that such problems do not arise in Canada and that all jurisdictions comply with the legislation.

Second, a system is as strong as its weakest part; therefore, cooperation is essential if a system is to work. All key players, including the federal government, provincial governments, regulatory organizations, professional associations, and educational institutions, need to collaborate with the aim of achieving a common goal. As it was shown in the case of the EU, European institutions, national governments, and professional bodies realized the importance of cooperation; therefore, all parts of the European system engaged in extensive debates to come to an agreement on mobility issues, and where necessary, they were willing to compromise. In the same way, federal and provincial governments in Canada need to cooperate with each other to develop a standardized system of credential recognition. Furthermore, co-ordination needs to be ensured also among provincial governments, and between provincial governments and regulatory bodies to ease mobility of professionals across provinces.

Third, the EU has developed a number of instruments to facilitate recognition of professionals´ qualifications. Among the most important ones are SOLVIT and the IMI system. As for SOLVIT, it provides help to EU citizens in case mistakes in the Internal Market are made. Although the Internal Market generally works well, EU professionals may sometimes encounter problems with getting their professional qualifications recognized, getting a residence permit, or accessing a chosen profession (employment). In all these instances, SOLVIT as an informal problem solving network is there to help (European Commission, n.d.,b). With regard to the IMI system, it provides a wide range of information about professionals to the regulatory bodies with the aim of promoting unhindered mobility of professionals within the EU. Such a source of information and communication is important not only to ensure that a professional in question is competent to practise in his/her field of

profession, but also to provide advice on what kind of training the professional may have to undertake to become eligible to practise in the chosen member state.

To conclude, the EU has focused on the practical side of things. It not only provided sources of information necessary for mobility purposes, but it also ensured that if problems in the Internal Market arise, EU citizens can access both formal and informal mechanisms for addressing them. In this regard, the EU can definitely serve as a good example for Canada. As Stephen Randall[113] (2007) noted, what Canada "can learn from the Europeans is the capacity to build real integration". However, if the FMRAC Agreement on national standards comes into effect, Canada will most likely get ahead of the EU with regard to physician mobility. In the EU, automatic recognition of physicians´ qualifications currently applies only to IMGs who are EU citizens. Therefore, recognition of physicians´ qualifications from third countries in the EU still remains to be resolved.

5. Conclusion

A well-known person in Canada once made a joke that if a pregnant woman has a choice between calling 9-1-1 and the taxi, she should call the taxi, because if anything happens down the road, the driver can make the delivery: he´s a foreign physician (Mugisho-Demu, 2009). Problems associated with qualification recognition are not new; many studies have acknowledged that IMGs face significant difficulties in pursuing medical profession in Canada. However, while difficulties with foreign qualification recognition have been part of the system in Canada for a long time, governments, professional regulatory organizations, and medical associations have now come to an agreement to (1) develop new assessment procedures available to all IMGs and (2) adopt national licensure standards for all physicians.

Canada has certainly taken some significant steps to ensure more efficient assessment and licensure policies. Its goal has been to establish a system for recognition of physician

[113] Stephen Randall is the Director of the Institute for United States Policy Research at the University of Calgary.

qualifications based on five principles: (1) public protection, (2) consistency across Canada, (3) fairness and access, (4) transparency (disclosure), and (5) collaboration amongst numerous parties—the federal and provincial governments, regulators, medical associations, employers, the individual seeking work in Canada (physicians), and the public (CNNAR, 2005, p. 3).

Regulatory bodies must have policies in place that maintain public protection. At the same time, physicians seeking to work in Canada must be provided with the best opportunity to realize their full potential in terms of practising their chosen profession. Therefore, it is essential that mechanisms and resources are available to assist with the regulatory process and integration into the Canadian workforce and that collaboration occurs to facilitate this process (CNNAR, 2005, p. 3).

Appendix 1

Glossary

- Accreditation: process of quality assurance through which accredited status is granted to an educational institution or program of study by responsible authorities. It affirms that standards of education established by professional authorities have been met (CICIC, 2003).
- Certificate of registration: wallet-size plastic card, which serves as an official proof of registration with a medical regulatory authority (MCC, 2011).
- Certification requirements: documented recognition by a governing body that a person has attained occupational proficiency (CICIC, 2003).
- Competent authority: any authority or body empowered by a member state specifically to issue or receive training diplomas and other documents or information and to receive applications, and take decisions (Eur-Lex, 2005).
- Credential: documented evidence of learning based on completion of a recognized program of study, training, work experience, or prior learning assessment. Degrees, diplomas, certificates, and licences are examples (CICIC, 2003).
- Directive: one of the EU legal instruments for implementing European policies. It obliges all member states to achieve a certain result but leaves them free to choose how to do so (Europa, 2010b).
- Foreign qualification recognition: process of verifying that the education and job experience obtained in another country are equal to the standards established for Canadian workers (HRSDC, 2005).
- General system for the recognition of qualifications: applies to all professions that are not covered by the sectoral system. Professions falling into this category are not adapted across the EU in terms of minimum education and training requirements.

General system is based on the principle of mutual recognition, without prejudice to the application of compensatory measures if there are "substantial differences between the training acquired by the person concerned and the training required in the host member state" (Europa, 2010c).

- Harmonization: process of bringing a number of different rules or systems in different countries into a position where they are parallel or similar to one another. The EU´s aim in terms of harmonization is to achieve consistent, not uniform, standards in order to facilitate the free movement (Politics Dictionary, 2011).
- International medical graduate: can refer to physicians who come from a wide range of background. For example, IMG may: (1) have independently practised in his/her country for several years; (2) have just recently completed his/her medical degree; (3) have completed a residency-training program; (4) have entered medical practice without any requirement of residency-training program; (5) be from a country with a similar/different medical education system to the Canadian (MCC, 2010).
- Licence: document used by some trades and professions to signify that the licence-holder meets competency and other requirements and is entitled to practise (CICIC, 2003).
- Licentiate of the Medical Council of Canada: credential conferred by the MCC. It is not a licence to practise medicine in Canada; rather, it attests (through a successful completion of the MCCQE1 and MCCQE2) that a physician has the knowledge and skills to practise medicine in Canada (Kendel, 2011a, p. 2; MCC, 2011).
- Mutual recognition agreement: agreement in which the respective regulatory authorities accept, in whole or in part, the regulatory authorizations obtained in the territory of the other Party or Parties to the agreement in granting their own authorization (Nicolaïdis, 1997).

- Non-regulated profession: professional activity for which there is no legal requirement or restriction on practice with regard to licences, certificates, or registration (CICIC, 2003).
- Occupational standard: knowledge, skills, abilities, and experience required for an occupation as established by a recognized body and against which the qualifications of an individual in that occupation are assessed (Knox, 2010, p. 3).
- Qualification: possession of knowledge, skills, and experience for entry to an educational program or practice in an occupation (CICIC, 2003).
- Qualified majority: it is the most common form of voting in the Council of Ministers in the EU. Since the 2007 enlargement a minimum of 255 votes out of 345 (73.9%) is required to reach a qualified majority. In addition, a majority of member states (in some cases two thirds) must approve the decision, and any member state may ask for confirmation that the votes cast in favour represent at least 62% of the EU´s total population (Europa, 2008).
- Regulated occupation: professional activity controlled by a national law and governed by a professional regulatory organization. The regulatory organization governing the profession has the authority to set entry requirements and standards of practice to assess applicants´ qualifications and credentials to certify, register, or license qualified applicants, and to discipline members of the profession (CICIC, 2003).
- Sectoral system for recognition of qualifications: applies to seven professions—medical doctors, general nurses, midwives, pharmacists, veterinary surgeons, and architects. This system provides for harmonization of minimum training requirements and automatic recognition of professional qualifications (European Commission, 2010c, p. 5).

Appendix 2

Abbreviations

ACMT	Advisory Committee on Medical Training
AEMH	European Association of Senior Hospital Physicians
AIT	Agreement on Internal Trade
BSD	Board of Saskatchewan Division
CAPE	Clinicians´ Assessment and Professional Enhancement
CaRMS	Canadian Residency Matching Service
CCPS	Council of the College of Physicians and Surgeons
CFPC	College of Family Physicians of Canada
CIHI	Canadian Institute for Health Information
CMA	Canadian Medical Association
CMG	Canadian Medical Graduate
COF	Council of the Federation
CPME	Standing Committee of European Doctors
CSA	Canadian Studying Abroad
CSOPH	Senior Officials on Public Health
CPSS	College of Physicians and Surgeons of Saskatchewan
EC	European Community
ECSC	European Coal and Steel Community
EEC	European Economic Community
ECJ	European Court of Justice
EU	European Union
FAIMER	Foundation for Advancement of International Medical Education and Research

FEMS	European Federation of Salaried Doctors
FLMM	Forum of Labour Market Ministers
FMRAC	Federation of Medical Regulatory Authorities of Canada
GMC	General Medical Council
IMG	International Medical Graduate
IMI	Internal Market Information
LMCC	Licentiate of the Medical Council of Canada
LMCG	Labour Market Coordinating Group
MCCEE	Medical Council of Canada Evaluating Exam
MCCQE	Medical Council of Canada Qualifying Exam
PCR	Physician Credentials Repository
PWG	Permanent Working Group of European Junior Doctors
RCPS	Royal College of Physicians and Surgeons
SEA	Single European Act
SLIM	Simpler Legislation for Internal Market
SMA	Saskatchewan Medical Association
TILMA	Trade, Investment and Labour Mobility Agreement
UEMO	European Union of General Practitioners
UEMS	European Union of Medical Specialists

Bibliography

ACCA (Association of Chartered Certified Accountants). (2001). The mobility of professionals: A new perspective. Retrieved April 20, 2011 from http://www2.accaglobal.com/pubs/canada/members/resources/technical/oct01_rec_notes.pdf

ACE (Admissions Officers & Credential Evaluators). (n.d.). European Union directives for professional recognition. Retrieved February 15, 2011 from http://www.aic.lv/ace/ace_disk/Recognition/dir_prof/GENERAL/index.htm

AIPSO (Association of International Physicians and Surgeons of Ontario). (2000). Barriers to licensing in Ontario for international physicians. Retrieved February 13, 2011 from http://www.cassaonline.com/prompt/Library/Docs/AIPSOBarriers2%20Jun%2000.pdf

AIT (Agreement on Internal Trade): Consolidated version. (2009). Retrieved January 15, 2011 from http://www.ait-aci.ca/en/ait/ait_en.pdf

AIT (Agreement on Internal Trade). (1995). Retrieved January 15, 2011 from http://www.ait-aci.ca/index_en/ait.htm

Alboim, N., & McIsaac, E. (2007). Making the connections: Ottawa´s role in immigrant employment. *IRPP Choices*, *Vol. 13*, No. 3, pp. 1-24. Montreal, QC: Institute for Research on Public Policy. Retrieved February 17, 2011 from http://www.irpp.org/choices/archive/vol13no3.pdf

Allen, J. (2001). Ensuring quality of health care providers within the single market. Retrieved March 18, 2011 from http://www.ose.be/health/files/respaper/allenpaper.pdf

Audas, R., Ross, A., & Vardy, D. (2005a). Provisionally licensed international medical graduates: Recruitment and retention in Newfoundland and Labrador. St. John's, NL: Memorial University of Newfoundland. Retrieved April 20, 2011 from http://canada.metropolis.net/pdfs/licensed_intl_med_grads_e.pdf

Audas, R., Ross, A., & Vardy, D. (2005b). The use of provisionally licensed international medical graduates in Canada. *Canadian Medical Association Journal, Vol. 173,* No. 11, pp. 1315-1316. Retrieved April 5, 2011 from http://www.cmaj.ca/cgi/content/full/173/11/1315

Audas, R., Ross, A., & Vardy, D. (2004). The role of international medical graduates in the provision of physician services in Atlantic Canada. Retrieved March 6, 2011 from http://www.mun.ca/harriscentre/reports/research/2006/IMG-Atlantic_Metropolis-FINAL.pdf

Bacic, J. (2008). CMA says health care system is failing Canadians. *Canadian Psychiatry Aujourd´hui, Vol. 4,* No. 1. Retrieved February 2, 2011 from http://publications.cpa-apc.org/browse/documents/300

Baergen, E. H. (2006). Saskatchewan Medical Association (SMA). *The Encyclopedia of Saskatchewan.* Retrieved January 23, 2011 from http://esask.uregina.ca/entry/saskatchewan_medical_association_sma.html

Bearley, S. (2005). Harmonisation of specialist training requirements in Europe: Is it a mirage? *British Medical Journal, Vol. 311,* pp. 297-299. Retrieved April 7, 2011 from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2550364/pdf/bmj00603-0029.pdf

Baerlocher, M. (2006). The important of foreign-trained physicians to Canada. *Clinical and Investigative Medicine, Vol. 29,* No. 3, pp. 151-153. Retrieved April 14, 2011 from http://www.ncbi.nlm.nih.gov/pubmed/17058433

Baranek, P. M. (2005). A review of scopes of practice of health professions in Canada: A Balancing Act. Toronto, ON: Health Council of Canada. Retrieved February 2, 2011 from http://healthcouncilcanada.ca/docs/papers/2005/Scopes_of_PracticeEN.pdf

Barer, M., & Stoddart, G. (1991). *Toward integrated medical resource policies for Canada.* Vancouver, BC: Centre for Health Services and Policy Research. Retrieved April 23, 2011 from http://www.chspr.ubc.ca/files/publications/1991/hpru91-06D.pdf

Basran, G. S., & Zong, L. (1998). Devaluation of foreign credentials as perceived by visible minority professional immigrants. *Canadian Ethnic Studies, Vol. 30,* No. 2, pp. 6-23.

Bauder, H. (2003). "Brain abuse", or the devaluation of immigrant labour in Canada. *Antipode, Vol. 35,* No. 4, pp. 699-717. Oxford, UK: Blackwell Publishing. Retrieved February 8, 2011 from http://onlinelibrary.wiley.com/doi/10.1046/j.1467-8330.2003.00346.x/pdf

Becklumb, P., & Elgersma, S. (2008). Recognition of the foreign credentials of immigrants. Library of Parliament. Revised by Benjamin R. Dolin & Margaret Young. Retrieved March 18, 2011 from http://www2.parl.gc.ca/Content/LOP/ResearchPublications/prb0429-e.pdf

Beek, E. (2007). The slow implementation of EC Directives. Bachelor thesis. Enschede, Netherlands: University of Twente. Retrieved January 6, 2011 from http://essay.utwente.nl/767/1/scriptie_ter_Beek.pdf

Bergeron, M. J. (2009). Characteristics of native-born and foreign-born migrants In Canada: An empirical investigation. Master Thesis. Halifax, NS: Saint Mary´s University.

BIS (Department for Business Innovation & Skills). (n.d.). Internal Market Information (IMI) system. Retrieved March 16, 2011 from http://www.bis.gov.uk/policies/europe/eu-services-directive/internal-market-information-system

Blackmer, J. (2007). Professionalism and the medical association. World Medical Association. Retrieved February 17, 2011 from http://www.wma.net/en/30publications/40background_docs/White_Paper.pdf

Blitz, B. K. (1999). Professional mobility and the mutual recognition of qualifications in the European Union: Two institutional approaches. *Comparative Education Review, Vol. 43*, No. 3, pp. 311-331. The University of Chicago Press on behalf of the Comparative and International Education Society.

BMA (British Medical Association). (2009). European and international medical bodies. Retrieved April 30, 2011 from http://www.bma.org.uk/images/europeanandinternationalmedicalbodies_tcm26-189007.pdf

Bottrell, L. (October 15, 2010). New assessment process to ease recruitment of foreign-trained physicians. *The Observer*. Retrieved April 5, 2011 from http://www.carlyleobserver.com/article/20101015/CARLYLE0101/310159979/-1/CARLYLE/new-assessment-process-to-ease-recruitment-of-foreign-trained

Bourgeault, I. L. (March 28, 2007). Health care brain waste needs a long-term policy solution. *Embassy*. Retrieved March 12, 2011 from http://embassymag.ca/page/view/.2007.march.28.solution

Bowmer, I. (March 15, 2011). Telephone interview.

Broten, L. (2008). Report on removing barriers for international medical doctors. Retrieved February 12, 2011 from http://www.health.gov.on.ca/english/public/pub/ministry_reports/removing_barriers/removing_barriers.pdf

Bryce, G., & Bayne, L. (2010). An evaluation of the relationship between the College of Registered Nurses of British Columbia and the Canadian Nurses Association. College of Registered Nurses of British Columbia. Retrieved March 3, 2011 from https://www.crnbc.ca/crnbc/Documents/EvaluationCRNBCCNA.pdf

CAETO (Canadian Alliance of Education and Training Organizations). (2004). Foreign credential recognition: An overview of practice in Canada. Retrieved February 15, 2011 from http://www.arts.yorku.ca/soci/anisef/research/documents/ForeignCredentialRecognition.pdf

Canadian Chamber of Commerce. (1998). The Agreement on Internal Trade: Taking stock after three years. Retrieved April 6, 2011 from http://global-economics.ca/internaltrade.3years.pdf

CaRMS (Canadian Resident Matching Service). (2010a). Main residency match R-1. Retrieved March 18, 2011 from http://www.carms.ca/eng/r1_eligibility_prov_e.shtml#ontario

CaRMS (Canadian Resident Matching Service). (2010b). Summary of match results: 2010 First Iteration R-1 Match. Retrieved March 18, 2011 from http://www.carms.ca/pdfs/2010R1_MatchResults/Summary%20of%20Match%20Results_en.pdf

CaRMS (Canadian Resident Matching Service). (2010c). International medical graduates. Retrieved March 18, 2011 from http://www.carms.ca/pdfs/2010R1_MatchResults/IMG%20positions%20comparison_en.pdf

CaRMS (Canadian Resident Matching Service). (n.d.). About CaRMS. Retrieved March 18, 2011 from http://www.carms.ca/eng/index.shtml

Carson, J. (2001). Legal issues in standard setting for licensure and certification. In Gregory J. Cizek (Eds.), *Setting performance standards: Concepts, methods, and perspectives.* Mahwah, NJ: Lawrence Erlbaum Associates.

CFPC (College of Family Physicians of Canada). (2010). Accreditation. Retrieved April 5, 2011 from http://www.cfpc.ca/english/cfpc/education/accreditation/default.asp?s=1

CGA (Certified General Accountants) of Canada. (2001). Canada´s Agreement on Internal Trade: It can work if we want it to. Vancouver, BC: Certified General Accountants Association. Retrieved March 7, 2011 from http://www.cga-canada.org/en-ca/ResearchReports/ca_rep_2001-05_ait.pdf

Chamber of Commerce. (2008). A resolution to replace the Agreement on Internal Trade (AIT). Retrieved March 9, 2011 from http://www.chamber.ca/images/uploads/Resolutions/2008/Government-Operations/G-AIT.pdf

Childs, R., & Herbert, M. (2007). Assessing IMG performance at Ontario medical schools 2002 – 2006. Final report. Toronto, ON: Ontario Institute for Studies in Education of the University of Toronto for the Council of Faculties of Medicine of the Council of Ontario Universities. Retrieved April 20, 2011 from http://www.pgme.utoronto.ca/Assets/PGME+Digital+Assets/Agendas+and+Minutes/perf+report.pdf

CICIC (Canadian Information Centre for International Credentials). (2010). Assessment and recognition of credentials for the purpose of employment in Canada. Retrieved January 29, 2011 from http://www.cicic.ca/404/Recognition_of_Professional_Qualifications.canada

CICIC (Canadian Information Centre for International Credentials). (2003). Guide to terminology usage in the field of credentials recognition and mobility in English in Canada. Retrieved January 29, 2011 from http://www.cicic.ca/410/guide-to-terminology-usage-in-the-field-of-credentials-recognition-in-canada.canada

CIHI (Canadian Institute for Health Information). (2009). Supply, distribution, and migration of Canadian physicians. Ottawa, ON: Canadian Institute for Health Information. Retrieved March 17, 2011 from http://secure.cihi.ca/cihiweb/products/SMDB_2008_e.pdf

CIHI (Canadian Institute for Health Information). (2008). Supply, distribution and migration of Canadian physicians, 2007. Ottawa, ON: Canadian Institute for Health Information. Retrieved March 17, 2011 from http://secure.cihi.ca/cihiweb/products/SupDistandMigCanPhysic_2007_e.pdf

CIHI (Canadian Institute for Health Information). (2007). Supply, distribution and migration of Canadian physicians, 2006. Ottawa, ON: Canadian Institute for Health Information. Retrieved March 17, 2011 from http://secure.cihi.ca/cihiweb/products/SupDistandMigCanPhysic_2006_e.pdf

CIHI (Canadian Institute for Health Information). (2006). Supply, distribution and migration of Canadian physicians, 2005. Ottawa, ON: Canadian Institute for Health Information. Retrieved March 17, 2011 from http://secure.cihi.ca/cihiweb/products/supply_distribution_migration_canadian_physicians_2005_e.pdf

CIHI (Canadian Institute for Health Information). (2001). Supply, distribution and migration of Canadian physicians, 2001. Ottawa, ON: Canadian Institute for Health Information.

CNHC (Complementary & Natural Healthcare Council). (n.d.). Key characteristics of regulatory bodies and professional bodies. Retrieved April 2, 2011 from http://www.aor.org.uk/uploads/CNHC%20DL%20Leaflet2.pdf

CNNAR (Canadian Network of National Associations of Regulators). (2005). Recognition of professional qualifications to work in regulated professions in Canada. Retrieved March 17, 2011 from

http://www.ccpnr.ca/PDFs/CNNAR_Recognition_of_Professional_Qualifications_to_Work_in_Canada_FINAL_Sept_19_2005.pdf

COF (Council of the Federation). (n.d.). About the Council. Retrieved March 20, 2011 from http://www.councilofthefederation.ca/aboutcouncil/aboutcouncil.html

COF (Council of the Federation). (2008). Trade: Building our strengths in Canada and abroad. Quebec. News Release. Retrieved April 3, 2011 from http://www.councilofthefederation.ca/pdfs/COMMUNIQUE_TRADE_clean.pdf

COF (Council of Federation). (2007). Premiers strengthen trade. Retrieved April 3, 2011 from http://www.councilofthefederation.ca/pdfs/Competitiveness_Trade_Aug8_EN.pdf

Collett, E., & Fuller, G. (2009). Mobility of the skilled workforce in Europe: The role of qualifications recognition. Prepared for a European Union-Canada Roundtable. Brussels, Belgium: European Policy Centre. Retrieved March 17, 2011 from http://www.ppforum.ca/sites/default/files/backgrounder_EU_Final.pdf

Collier, R. (2010). Higher percentage of medical school graduates seek family medicine residencies. *Canadian Medical Association Journal, Vol. 182*, No. 9, pp. E411-E412. Retrieved April 3, 2011 from http://www.cmaj.ca/cgi/content/full/182/9/E411

Competition Bureau. (2007). Self-regulated professions: Balancing competition and regulation. Gatineau. Retrieved February 2, 2011 from http://www.competitionbureau.gc.ca/eic/site/cb-bc.nsf/vwapj/Professions%20study%20final%20E.pdf/$FILE/Professions%20study%20final%20E.pdf

Conference Board of Canada. (2007). Achieving public protection through collaborative self-regulation: Reflections for a new paradigm. Retrieved April 13, 2011 from http://healthprofessions.dal.ca/Files/14._Conf._Board__Regulation_of_IP_collaborative_practice.pdf

Costigliola, V. (2011). Post-graduate studies in medicine: Legal regulation in the European Union. European Medical Association. Retrieved March 6, 2011 from http://www.emanet.org/post-graduate.cfm

CPA (Canadian Psychological Association). (n.d.). Canada´s Agreement on Internal Trade (AIT): Some things to think about for the practice and mobility of psychology and other health practitioners. Retrieved March 9, 2011 from http://www.cpa.ca/cpasite/userfiles/Documents/Practice_Page/AIT_final.pdf

CPME (Standing Committee of European Doctors). (2011). CPME response to the public consultation on the recognition of professional qualifications directive. Retrieved March 5, 2011 from http://www.efnweb.org/version1/en/documents/CPME-2011-015.CPME.response.PQD.consultation.FINAL.PDF

CPME (Comité Permanent des Médecins Européens). (1998). Motion on the future of the ACMT. Retrieved March 5, 2011 from http://cpme.dyndns.org:591/adopted/CP98_051EN.pdf

CPME (Comité Permanent des Médecins Européens). (n.d.,a). Welcome to the website of the Standing Committee of European Doctors. Retrieved March 5, 2011 from http://www.cpme.be/index.php

CPME (Comité Permanent des Médecins Européens). (n.d.,b). CPME members. Retrieved March 5, 2011 from http://www.cpme.be/content.php?c=aboutcpme_members

CPSA (College of Physicians and Surgeons of Alberta). (n.d.). Labour mobility agreements. Retrieved April 25, 2011 from http://www.cpsa.ab.ca/Services/Registration_Department/Alberta_Medical_Licence/AIT_TILMA.aspx

CPSO (College of Physicians and Surgeons of Ontario). (2011). Council elections. Retrieved from http://www.cpso.on.ca/members/elections/default.aspx?id=1942

CPSO (College of Physicians and Surgeons of Ontario). (2004). Tackling the doctor shortage. A discussion paper. Retrieved April 13, 2011 from http://www.cpso.on.ca/uploadedFiles/policies/positions/resourceinitiative/Doctor%20shortage.pdf

CPSO (College of Physicians and Surgeons of Ontario). (n.d.). FMRAC Agreement on national standards. Retrieved April 13, 2011 from http://www.cpso.on.ca/registration/default.aspx?id=3886

CPSO (College of Physicians and Surgeons of Ontario). (n.d.). Self/regulation and the practice of medicine. Retrieved April 13, 2011 from http://www.cpso.on.ca/aboutus/

CPSS (College of Physicians and Surgeons of Saskatchewan). (n.d.,a). Code of ethics. Retrieved March 8, 2011 from http://www.quadrant.net/cpss/communication/brochures/ethics.html

CPSS (College of Physicians and Surgeons of Saskatchewan. (n.d.,b). General information. Retrieved March 8, 2011 from http://www.quadrant.net/cpss/college/info.html

Crisp, A. H. (1990). Medical training in the European Community. *Postgraduate Medical Journal, Vol. 66*, No. 778, pp. 627-638. AEMIE.

Cruess, S. R., & Cruess, R. L. (2005). The medical profession and self-regulation: A current challenge. *Virtual Mentor, Vol. 7,* No. 4. Retrieved March 12, 2011 from http://virtualmentor.ama-assn.org/2005/04/oped1-0504.html

Cruther, R. A., Banner, S. R., Szafran, O., & Watanabe, M. (2003). Characteristics of international medical graduates who applied to the CaRMS 2002 match. *Canadian Medical Association Journal, Vol. 168,* No. 9, pp. 1119-1123. Retrieved May 1, 2011 from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC153680/

CTHRC (Canadian Tourism Human Resource Council). (January 20, 2009). First Ministers endorse full labour mobility across Canada. Retrieved April 13, 2011 from

http://cthrc.ca/en/member_area/member_news/first_ministers_endorse_full_labour_mobility_across_canada

Dahrendorf, R. (1984). In defence of the English professions. *Journal of the Royal Society of Medicine, Vol. 77*, pp. 178-185. Retrieved February 2, 2011 from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1439835/pdf/jrsocmed00225-0016.pdf

Dauphinee, D. (2006). The circle game: Understanding physician migration patterns. *Academic Medicine, Vol. 81*, Issue 12, pp. S49-S54. Retrieved March 19, 2011 from http://journals.lww.com/academicmedicine/fulltext/2006/12001/the_circle_game__understanding_physician_migration.10.aspx

Dauphinee, D. (2003). Introducing international medical graduates into health care delivery in Canada: Attempting to resolve years of discontinuity between immigration policy and implementation strategies in the field. Paper prepared for the 7th International Medical Workforce Conference. Oxford: UK.

Davis, P. (2011). Personal interview.

De Mestral, A., & Winter, J. (2001). Mobility rights in the European Union and Canada. *McGill Law Journal, Vol. 46*, pp. 979-1009. Retrieved March 5, 2011 from http://lawjournal.mcgill.ca/documents/46.4.deMestralWinter.pdf

Decter, M. (1995). Structuring medical manpower: The Canadian response. *Journal of the Royal Society of Medicine, Vol. 88*, Supplement 26, pp. 35-38. Retrieved April 3, 2011 from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1295026/pdf/jrsocmed00060-0038.pdf

Dove, N. (2009). Can international medical graduates help solve Canada´s shortage of rural physicians? *Canadian Journal of Rural Medicine, Vol. 14*, No. 3, pp. 120-123. Retrieved April 15, 2011 from

http://prismadmin.cma.ca/multimedia/staticContent/HTML/N0/l2/cjrm/vol-14/issue-3/pdf/pg120.pdf

Dumont, J., Zurn, P., Church, J., & Le Thi, Ch. (2008). International mobility of health professionals and workforce management in Canada: Myths and realities. OECD Working Paper No. 40. Paris, France: OECD. Retrieved February 8, 2011 from http://www.oecd.org/dataoecd/7/59/41590427.pdf

EFCA (European Federation of Engineering Consultancy Associations). (2001). Internal market: Commission launches consultation on new EU regime for recognition of professional qualifications. *ECFA Bulletin*, Issue 83. Retrieved March 19, 2011 from http://www.efcanet.org/downloads/archive/4b3f2ec0-a9f5-405a-8de8-79bc01312bc3.pdf

Enemark, S., & Plimmer, F. (2002). Mutual recognition of professional qualifications. FIG Task Force. Retrieved March 11, 2011 from http://www.fig.net/pub/figpub/pub27/figpub27.pdf

Eur-Lex. (2005). Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications (Text with EEA relevance). *Official Journal of European Union,* L 255, p. 22 – 142. Retrieved April 2, 2011 from http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2005:255:0022:0142:en:PDF

Eur-Lex. (2004). Amended proposal for a Directive of the European Parliament and of the Council on the recognition of professional qualifications (presented by the Commission pursuant to Article 250 (2) of the EC Treaty). COM(2004)317. Retrieved March 3, 2011 from http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:52004PC0317:EN:NOT

Eur-Lex. (1993). Council directive 93/16/EEC of 5 April 1993 to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence

of formal qualifications. *Official Journal of European Union*, L 165, p. 0001 – 0024. Retrieved March 3, 2011 from http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31993L0016:EN:HTML

Eur-Lex. (1992). Treaty on the European Union. *Official Journal of the European Union*, C 191. Retrieved March 3, 2011 from http://eur-lex.europa.eu/en/treaties/dat/11992M/htm/11992M.html

Eur-Lex. (1989). Council Directive 89/48/EEC of 21 December 1988 on a general system for the recognition of higher-education diplomas awarded on completion of professional education and training of at least three years´ duration. *Official Journal of the European Communities*, L 19, p. 16 – 23. Retrieved March 3, 2011 from http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31989L0048:EN:HTML

Eur-Lex. (1975a). Council Directive 75/362/EEC of 16 June 1975 concerning the mutual recognition of diplomas, certificates and other evidence of formal qualifications in medicine, including measures to facilitate the effective exercise of the right of establishment and freedom to provide services. *Official Journal of European Communities*, L 167, p. 0001 – 0013. Retrieved March 3, 2011 from http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31975L0362:EN:HTML

Eur-Lex. (1975b). Council Directive 75/363/EEC of 16 June 1975 concerning the coordination of provisions laid down by law, regulation or administrative action in respect of activities of doctors. *Official Journal of the European Communities*, L 167, p. 14 – 16. Retrieved March 3, 2011 from http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31975L0363:en:NOT

Eur-Lex. (1975c). 75/364/EEC: Council Decision of 16 June 1975 setting up an Advisory Committee on Medical Training. *Official Journal of the European Communities*, L 167,

p. 17 – 18. Retrieved March 3, 2011 from http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31975D0364:EN:NOT

Eur-Lex (1974). Council Resolution of 6 June 1974 on the mutual recognition of diplomas, certificates and other evidence of formal qualifications. *Official Journal of the European Communities*, C 98, p. 1. Retrieved March 3, 2011 from http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31974Y0820%2801%29:EN:NOT

Eur-Lex. (n.d.). Bilingual display. Retrieved March 3, 2011 from http://eur-lex.europa.eu/Notice.do?mode=dbl&lang=en&ihmlang=en&lng1=en,cs&lng2=bg,cs,da,de,el,en,es,et,fi,fr,hu,it,lt,lv,mt,nl,pl,pt,ro,sk,sl,sv,&val=469783:cs&page=

EURACT (European Academy of Teachers in General Practice/Family Medicine). (n.d.). Statement on selection of trainers and teaching practices for specific training in general practice. Retrieved April 11, 2011 from http://www.euract.org/index.php?folder_id=26

Europa. (July 13, 2010a). Free movement rights for workers and Eurobarometer survey on labour mobility. *Press Releases RAPID*. Retrieved February 26, 2011 from http://europa.eu/rapid/pressReleasesAction.do?reference=MEMO/10/322

Europa. (2010b). Directive. Retrieved February 26, 2011 from http://europa.eu/legislation_summaries/institutional_affairs/decisionmaking_process/l14527_en.htm

Europa. (2010c). System for the recognition of professional qualifications. Retrieved February 26, 2011 from http://europa.eu/legislation_summaries/education_training_youth/vocational_training/c11065_en.htm

Europa. (2009). The Internal Market Information System. Retrieved February 26, 2011 from http://europa.eu/legislation_summaries/internal_market/internal_market_general_framework/mi0005_en.htm

Europa. (2008). The EU at glance: How does the EU work? Retrieved February 26, 2011 from http://europa.eu/abc/12lessons/lesson_4/index_en.htm

Europa. (2007). Medicine: Mutual recognition of qualifications. Retrieved February 26, 2011 from http://europa.eu/legislation_summaries/other/l23021_en.htm

Europa. (July 2, 2001). Professional qualifications: Commission launches open consultation on new EU regime. *Press Releases RAPID.* Retrieved February 26, 2011 from http://europa.eu/rapid/pressReleasesAction.do?reference=IP/01/929&format=HTML&aged=0&language=EN&guiLanguage=en

Europa. (n.d.). EU institutions and other bodies. Retrieved February 26, 2011 from http://europa.eu/institutions/index_en.htm

European Commission. (2011a). Doctors. Retrieved March 7, 2011 from http://ec.europa.eu/internal_market/qualifications/directive_in_practice/doctors_en.htm

European Commission. (2011b). Recognition of professional experience. Retrieved March 7, 2011 from http://ec.europa.eu/internal_market/qualifications/directive_in_practice/recognition_en.htm

European Commission. (2011c). Recognition of professional experience. Retrieved March 7, 2011 from http://ec.europa.eu/internal_market/qualifications/directive_in_practice/recognition_en.htm

European Commission. (2010a). General system. Retrieved March 7, 2011 from http://ec.europa.eu/internal_market/qualifications/general-system_en.htm

European Commission. (2010b). Specific sectors. Retrieved March 11, 2011 from http://ec.europa.eu/internal_market/qualifications/specific-sectors_en.thm

European Commission (2010c). Directive 2005/36/EC. Retrieved March 7, 2011 from http://ec.europa.eu/internal_market/qualifications/future_en.htm

European Commission. (2010d). Useful links. Retrieved March 5, 2011 from http://ec.europa.eu/internal_market/imi-net/links_en.html

European Commission. (2010e). Making legislation work better for citizens and business: The Internal Market Information System (IMI). Retrieved March 7, 2011 from http://ec.europa.eu/internal_market/imi-net/docs/imi_presentation_112007_en.pdf

European Commission. (2010f). Statistics on the use of the Internal Market Information system. Retrieved March 5, 2011 from http://ec.europa.eu/internal_market/imi-net/docs/statistics_2010_en.pdf

European Commission. (2010g). Commission staff working document on the transposition and implementation of the professional qualifications Directive (Directive 2005/36/EC). Retrieved March 8, 2011 from http://ec.europa.eu/internal_market/qualifications/docs/evaluation/staff-working-doc_en.pdf

European Commission. (2009). Scoreboard on the professional qualifications Directive (Directive 2005/36/EC). Retrieved March 7, 2011 from http://ec.europa.eu/internal_market/qualifications/docs/scoreboard_en.pdf

European Commission. (2005). New measures to improve EU job mobility for professionals. Retrieved March 8, 2011 from http://ec.europa.eu/internal_market/smn/smn39/docs/specialfeature_en.pdf

European Commission. (2002). The results of the European Commission consultation exercise on the future regime of professional recognition. Retrieved March 5, 2011

from http://ec.europa.eu/internal_market/qualifications/docs/2001-newdir/2002-02-consultation-answers_en.pdf

European Commission. (1957). The Treaty of Rome. Rome.. Retrieved March 9, 2011 from http://ec.europa.eu/economy_finance/emu_history/documents/treaties/rometreaty2.pdf

European Commission. (n.d.,a). Free movement of workers. Retrieved March 7, 2011 from http://ec.europa.eu/social/main.jsp?catId=458

European Commission. (n.d.,b). About SOLVIT. Retrieved March 5, 2011 from http://ec.europa.eu/solvit/site/about/index_en.htm

European Parliament. (2009a). Oral question with debate: Implementation of Directive 2005/36/EC. Retrieved March 12, 2011 from http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+OQ+O-2009-0108+0+DOC+XML+V0//EN

European Parliament. (2009b). Debates: Mutual recognition of professional qualifications (debate). Retrieved March 12, 2011 from http://www.europarl.europa.eu/sides/getDoc.do?type=CRE&reference=20091217&secondRef=ITEM-002&language=EN. Broadcasted at http://news.bbc.co.uk/democracylive/hi/europe/newsid_8413000/8413064.stm

FEMS (European Federation of Salaried Doctors). (2006). Articles of Association effective from 13/05/2006. Retrieved March 15, 2011 from http://www.fems.net/English/Pages/Statuts.aspx

FLMM (Forum of Labour Market Ministers). (2005). Report of survey results: Inter-provincial labour mobility in Canada 2004/05.. Retrieved April 2, 2011 from http://www.ait-aci.ca/en/reports/01_10_2006/FLMM%20NATIONAL%20REPORT%20-%20APPROVED%20VERSION%20MAY%2018-2005.pdf

FMRAC (Federation of Medical Regulatory Authorities Canada). (2010). Mission. Retrieved April 4, 2011 from http://www.fmrac.ca/about-us/mission.html

FMRAC (Federation of Medical Regulatory Authorities Canada). (2009). Agreement on national standards for medical registration in Canada. Draft 8. Retrieved April 4, 2011 from http://www.quadrant.net/cpss/pdf/CPSS_National_Standards.pdf

Friedson, E. (1988). *Profession of medicine: Study of the sociology of applied knowledge.* New York, NY: Dodd Mead.

Garoupa, N. (2006). Regulation of legal and medical professions in the Us and Europe: A comparative analysis. Retrieved March 17, 2011 from http://www.fedea.es/pub/papers/2006/dt2006-11.pdf

Gerlinger, T., & Schmucker, R. (2007). Transnational migration of health professionals in the European Union. *Cadernos de Saúde Pública*, *Vol. 23*, Supplement 2, pp. S184-S192. Retrieved April 4, 2011 from http://www.scielosp.org/pdf/csp/v23s2/07.pdf

Girard, E., & Bauder, H. (2005). Barriers blocking the integration the integration of foreign-trained immigrant professionals: Implications for smaller communities in Ontario. Guelph, ON: University of Guelph. Retrieved March 17, 2011 from http://www.geography.ryerson.ca/hbauder/Immigrant%20Labour/immigrant_credentials.pdf

Gomez, R., & Gunderson, M. (2007). Barriers to the inter-provincial mobility of labour. Working paper 2007-09. Ottawa, ON: Industry Canada.

Government of Manitoba. (2006). The medical licensure program for international medical graduates (MLPIMG). Retrieved March 8, 2011 from http://www.gov.mb.ca/health/mlpimg/program2006.pdf

Government of Saskatchewan. (2009). Labour mobility. Retrieved February 17, 2011 from http://www.aeei.gov.sk.ca/labour-mobility

Health Canada. (2005). Health human resources: Balancing supply and demand. Retrieved April 4, 2011 from http://www.hc-sc.gc.ca/sr-sr/pubs/hpr-rpms/bull/2004-8-hhr-rhs/method-eng.php

Health Canada. (2004). Royal Commission on Health Services, 1961 to 1964. Retrieved April 15, 2011 from http://www.hc-sc.gc.ca/hcs-sss/com/fed/hall-eng.php

Health Edition. (2010). New IMG assessment process in Saskatchewan. *Vol. 14*, No. 37. Retrieved April 4, 2011 from http://www.healthedition.com/article.cfm?articleID=8585

Hervey, T. K., & McHale, J. V. (2004). *Health law and the European Union*. Cambridge, UK: The University of Cambridge.

Hill, A. (September 17, 2010). New assessment of physicians to cause less disruption. *Daily Herald News.* Retrieved May 1, 2011 from http://www.paherald.sk.ca/News/Local/2010-09-17/article-1770658/New-assessment-of-physicians-to-cause-less-disruption/1

Hoßmann, I., Karsch, M., Klingholz, R., Köhncke, Y., Kröhnert, S., Pietschmann, C., & Sütterlin, S. (2008). The world growing – Europe in stagnation. Berlin, Germany: The Berlin Institute for Population and Development. Retrieved April 12, 2011 from http://www.berlin-institut.org/fileadmin/user_upload/Europa/Kurz_Europa_e_Map.pdf

Howell, E. (2008). Physician, count thyself. *Canadian Medical Association, Vol. 178*, No. 4, pp. 381-384. Retrieved February 17, 2011 from http://www.cmaj.ca/content/178/4/381.full

HRSDC (Human Resources and Skills Development Canada). (2009). Looking-ahead: A 10-year outlook for the Canadian Labour Market (2006-2015). Retrieved April 8, 2011 from http://www.hrsdc.gc.ca/eng/publications_resources/research/categories/labour_market_e/sp_615_10_06/page05.shtml#occupation

HRDSC (Human Resources and Skills Development Canada). (2010). Labour mobility. Retrieved April 3, 2011 from http://www.hrsdc.gc.ca/eng/workplaceskills/labour_mobility/index.shtml

HRSDC (Human Resources and Social Development Canada). (2005). Foreign credential recognition. Retrieved March 28, 2011 from http://www.hrsdc.gc.ca/en/cs/comm/hrsd/news/2005/050425bb.shtml

Hutten-Czapski, P. (2001). The Standing Senate Committee on Social Affairs, Science and Technology. Issue 17. *Society of Rural Physicians of Canada.* Retrieved April 14, 2011 from http://www.srpc.ca/PDF/kirkby-transcript.pdf

Industry Canada. (2009). Summary of the Agreement on Internal Trade. Retrieved March 18, 2011 from http://www.ic.gc.ca/eic/site/ait-aci.nsf/eng/il00020.html

Internal Trade Secretariat. (2009). Annual report 2008/2009. Retrieved May 1, 2011 from http://www.ait-aci.ca/en/reports/pdf/annual/2008-2009%20annual%20report.pdf

Karle, H., & Kennedy, T. E. (1989). Medical Education in the European Communities: Moving toward 1993 and beyond. *European Journal of Education*, *Vol. 24*, No. 4, pp. 399-410. Retrieved February 27, 2011 from http://www.jstor.org/pss/1503308

Keigley, T. (2009). European Union standards for nursing and midwifery: Information for accession countries. World Health Organization. Second edition. Retrieved March 17, 2011 from http://www.euro.who.int/__data/assets/pdf_file/0005/102200/E92852.pdf

Kendel, D. A. (March 16, 2011a). Email conversation.

Kendel, D. A. (March 16, 2011b). Personal interview.

Kendel, D. A. (2010). A new Saskatchewan based IMG assessment process. *DocTalk Newsletter*. Retrieved March 19, 2011 from http://www.quadrant.net/cpss/pdf/CPSS_Fall_2010_Newsletter.pdf

Kendel, D. A., & Dauphinee, W. D. (1994). Barriers to interprovincial physician mobility. *Canadian Medical Association Journal, Vol. 151*, No. 11, pp. 1579-1580. Retrieved March 19, 2011 from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1337368/?page=1

Kendel, D. A. (n.d.). Observations on the transition to national medical licensure standards in Canada. Letter from the Registrar. College of Physicians and Surgeons of Saskatchewan. Retrieved March 15, 2011 from http://www.quadrant.net/cpss/standards/message.html

Kenney, J. (2010). Pre-conference session: Foreign credential recognition in Canada and abroad. Speaking notes by the Honourable Jason Kenney at the 12th National Metropolis Conference. Retrieved February 25, 2011 from http://www.cic.gc.ca/english/department/media/speeches/2010/2010-03-18.asp

Knox, R. (2010). Who can work where: Reducing barriers to labour mobility in Canada. *Backgrounder*, No. 131. Ottawa, ON: C.D. Howe Institute.

Knox, R., & Karabegovic, A. (May 21, 2009). Time to end interprovincial barriers. *Financial Post.* Retrieved April 18, 2011 from http://network.nationalpost.com/np/blogs/fpcomment/archive/2009/05/21/time-to-end-interprovincial-barriers.aspx

Lange, S. (2001). The European Union of Medical Specialists and specialty training. *European Journal of Anaesthesiology, Vol. 18*, Issue, 9, pp. 561-562. Retrieved March 25, 2011 from http://journals.lww.com/ejanaesthesiology/Fulltext/2001/09000/The_European_Union_of_Medical_Specialists_and.1.aspx

Lefebvre, F. A. (December 9, 2009). Labour mobility and international medical graduates: Presentation to the House of Commons Standing Committee on Health. Second session. Retrieved March 15, 2011 from

http://www.parl.gc.ca/HousePublications/Publication.aspx?DocId=4314977&Language=E&Mode=1&Parl=40&Ses=2

Lenihan, D. (July 10, 2010). Foreign qualification recognition and Canada´s intergovernmental landscape. *Policy Options*. Institute for Research on Public Policy. Retrieved March 19, 2011 from http://www.irpp.org/po/archive/jul10/lenihan.pdf

Ling, K. 2007. Implementation of European Directive 2005/36/EC for health and social care professions in the UK: The European qualifications (health and social care professions) regulations 2007. Department of Health. Retrieved April 4, 2011 from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_074939.pdf

Macmillan, K. E., & Grady, P. (2007). A new prescription: Can the BC-Alberta TILMA resuscitate internal trade in Canada? *Backgrounder*, No. 106. Ottawa, ON: C. D. Howe Institute. Retrieved April 12, 2011 from http://global-economics.ca/cdhowe_backgrounder_106.pdf

Mathews, M. & Edwards, A., & Rourke, J. (2008). Retention of provisionally licensed international medical graduates: A historical cohort study of general and family physicians in Newfoundland and Labrador. *Open Medicine*, *Vol. 2*, No. 2, pp. E37-E44.

MCC (Medical Council of Canada). (2011). Licentiate of the Medical Council of Canada. Retrieved February 2, 2011 from http://www.mcc.ca/en/mcc_docs/licentiate.shtml

MCC (Medical Council of Canada). (2010). Information for international medical graduates. Retrieved February 2, 2011 from http://www.mcc.ca/en/IMGs.shtml

MCC (Medical Council of Canada). (n.d.). Registration to practise medicine in Canada. Retrieved February 2, 2011 from http://www.mcc.ca/pdf/Registration_Chart_en.pdf

McGrath, P., Wong, A., & Holewa, H. (2011). Canadian and Australian licensing policies for international medical graduates: A web-based comparison. *Education for Health*, *Vol.*

24, No. 1, pp. 1-13. Retrieved March 16, 2011 from http://www.educationforhealth.net/publishedarticles/article_print_452.pdf

McGuinty, D., Caplan, D., & Milloy, J. (2009). Agreement on Internal Trade: Proposal for exception. Toronto, ON: College of Physicians and Surgeons of Ontario. Retrieved March 8, 2011 from http://www.cpso.on.ca/uploadedFiles/downloads/cpsodocuments/policies/positions/submissions/AIT_McGuintyMay26_09.pdf

McMahon, S. (2009). Preliminary report on Canadian models for IMG competency assessment: Creating a fair and equitable fast track assessment process for international medical graduates. Calgary, AB: AIMGA. Retrieved March 25, 2011 from http://www.aimga.ca/news/REPORT_DECEMBER_2009.pdf

Medical Profession Act. (1981). Chapter M-10.1 of the *Statutes of Saskatchewan, 1980-1981*. Retrieved January 19, 2011 from http://www.qp.gov.sk.ca/documents/English/Statutes/Statutes/M10-1.pdf

Michelmann, H. J. (1979). Credentials, jurisdiction and mobility: Physicians in the European Community. *Journal of European Integration, Vol. 2,* No. 2, pp. 103-229.

MOHLTC (Ministry of Health and Long-Term Care). (2005). Guidelines for drafting conflict of interest regulations by health regulatory colleges. Retrieved February 2, 2011 from http://iris.ca/newsattach/MOHLTCguidelines05R.pdf

MOSAIC. (2006). Solutions for access: A report on the access to licensure in regulated professions for internationally trained professionals in British Columbia. Retrieved April 9, 2011 from http://www.bcitp.net/downloads/site2/ImprovingAccessToLicensure-ExecSummary.pdf

Mugisho-Demu, N. (December 9, 2009). Labour mobility and international medical graduates: Presentation to the House of Commons Standing Committee on Health.

Second session. Retrieved April 7, 2011 from http://www.parl.gc.ca/HousePublications/Publication.aspx?DocId=4314977&Language=E&Mode=1&Parl=40&Ses=2

National Medical Associations in Europe. (2009). A.E.M.H. (European Association of Senor Hospital Physicians). Retrieved March 18, 2011 from http://legeforeningen.no/id/155425.0

Nicolaïdis, K. (1997). Managed mutual recognition: The new approach to the liberalization of professional services. Retrieved March 13, 2011 from http://users.ox.ac.uk/~ssfc0041/managemr.htm

Nilsen, K. (2009). Backgrounder on TILMA and AIT. Retrieved February 2, 2011 from www.cla.ca/AM/CLA-AITandTILMAbackgrounderJan2009byNilsen.doc

OECD (Organization for Economic Coordination and Development). (2009). Practising physicians (doctors): Density per 1000 population. Retrieved April 6, 2011 from http://www.oecd-ilibrary.org/social-issues-migration-health/practising-physicians-doctors_20758480-table4

OECD (Organization for Economic Co-operation and Development). (2008). A profile of immigrant populations in the 21st century: Data from OECD countries. Paris, France: Organization for Economic Co-operation and Development.

Office of the Fairness Commissioner. (2010). Entry-to-practice requirements for five professions in five Canadian provinces: Physicians & surgeons. Summary. Retrieved January 16, 2011 from http://www.fairnesscommissioner.ca/en/publications/entry-to-practice_requirements/physicians.php

Ontario Medical Association (OMA) Human Resources Committee (OHRC) (2007). OMA position on physician workforce policy and planning revisited: Recommendations to address Ontario´s doctor shortage. *Ontario Medical Review, Vol. 74,* No. 2, pp. 17-26.

Politics Dictionary. (2011). Harmonisation. Retrieved February 2, 2011 from http://www.politicsdictionary.com/definition/harmonisation.html

Pong, R., & Pitblado, J. (2005). Geographic distribution of physicians in Canada: Beyond how many and where. Ottawa, ON: Canadian Institute for Health Information. Retrieved April 8, 2011 from http://secure.cihi.ca/cihiweb/products/Geographic_Distribution_of_Physicians_FINAL_e.pdf

PWG (Permanent Working Group of European Junior Doctors). (1976). Statutes: Charter of the Permanent Working Group of European Junior Doctors. Retrieved March 3, 2011 from http://www.juniordoctors.eu/content/statutes

Rachlis, M., Evans, R. G., Lewis, P., & Barer, M. (2001). Revitalizing Medicare: Shared problems, public solutions. Prepared for the Tommy Douglas Research Institute. Vancouver, BC: Centre for Health Services and Policy Research. Retrieved February 2, 2011 from http://www.chspr.ubc.ca/files/publications/2001/hpru01-02D_tommydouglaspaper.pdf

Randall, S. (2007). Interview with Stephen Randall. Foreign Affairs and International Trade Canada. Retrieved April 9, 2011 from http://www.international.gc.ca/cip-pic/discussions/NA-AN/video/randall.aspx?lang=eng

Reitz, J. G. (2004). The institutional context of immigration policy and immigrant skill utilization in Canada. Toronto, ON: University of Toronto. Retrieved March 18, 2011 from http://www.utoronto.ca/ethnicstudies/skillutilization.pdf

RICS (Royal Institution of Chartered Surveyors). (2010). Recognition of Professional qualifications in the EU – FAQ. EU Policy and Public Affairs. Retrieved March 19, 2011 from http://www.rics.org/site/download_feed.aspx?fileID=6537&fileExtension=PDF

RN Network of BC. (2010). Differentiating the roles of regulatory bodies and associations for health professionals: A background document. Retrieved February 2, 2011 from http://www.nursing.ubc.ca/scholarship/rnnetwork/documents/Differentiating%20the%20Roles%20of%20Regulatory%20Bodies%20and%20Associations%20%20-%20Feb%202010.pdf

Romanow, R. (2002). Building on values: The future of health care in Canada—Final Report. Ottawa, ON: Commission on the Future of Health Care in Canada. Retrieved January 8, 2011 from http://dsp-psd.pwgsc.gc.ca/Collection/CP32-85-2002E.pdf

Rowe, A. (2010). Reflections on the Standing Committee of European Doctors´ (CPME) fiftieth anniversary 1959 – 2009. *World Medical Journal, Vol. 56,* pp. 14-18. Retrieved April 9, 2011 from http://cpme.dyndns.org:591/adopted/WMJ.vol.56.pp.014-018.2010.pdf

Royal College of Nursing. (2011). EU policy briefing and consultation: Review of EU mutual recognitions of professional qualifications legislation (Directive 2005/36/EC). *Policy and International Department.* Retrieved March 15, 2011 from http://www.rcn.org.uk/__data/assets/pdf_file/0010/359677/Policy_Brief_and_consultation_MRPQ_Jan2011.pdf

Rytz, B. K., Sylvest, J., & Pedersen, K. G. (2009). Study on the Transposition of the Directive on the recognition of professional qualifications. Requested by the European Parliament´s Committee on Internal Market and Consumer Protection. Retrieved March 18, 2011 from http://www.europarl.europa.eu/activities/committees/studies/download.do?language=fr&file=27071

Sallie, N. (2004). The challenges of the free movement of health professionals. In Martin Mckee, Laura MacLehose, & Ellen Nolte (Eds.), *Health policy and European Union*

enlargement. New York, NY: World Health Organization. Retrieved February 8, 2011 from http://www.euro.who.int/__data/assets/pdf_file/0004/98392/E82999.pdf

Samuel, J. (2004). Are there racial barriers to access to professions and trades for the foreign-trained in Ontario? Race policy dialogue conference paper. Toronto, ON: Ontario Human Rights Commission. Retrieved April 9, 2011 from http://www.ohrc.on.ca/en/issues/racism/racepolicydialogue/js

Saskatchewan Immigration. (2009). Internationally educated health professionals: Steps to licensing. Retrieved February 17, 2011 from http://www.saskimmigrationcanada.ca/family-physicians-eligible-to-apply-process-map

Saskatchewan Medical Association Act. (1999). Chapter 04 of the *Statutes of Saskatchewan, 1999*. Retrieved February 19, 2011 from http://www.qp.gov.sk.ca/documents/english/private/acts/PR-S26-1.PDF

Saskatchewan Ministry of Health. (2010a). Saskatchewan-based assessment of family medicine international medical graduates (IMGs): Questions and answers for IMGs. Retrieved March 2, 2011 from http://www.health.gov.sk.ca/adx/aspx/adxGetMedia.aspx?DocID=d43cd5e0-3319-492d-ba5b-9d1829abbe11&MediaID=4558&Filename=physician-img-assessment-qandas-oct-2010.pdf&l=English

Saskatchewan Ministry of Health. (2010b). Saskatchewan-based assessment of international medical graduates (IMGs): Information sheet. Retrieved March 2, 2011 from http://www.health.gov.sk.ca/adx/aspx/adxGetMedia.aspx?DocID=f1e5ea56-171b-406b-b797-c3e26a826ef1&MediaID=4559&Filename=physician-img-assessment-information-sheet-sep-2010.pdf&l=English

Saskatchewan Ministry of Health. (2009). Physician recruitment strategy. Retrieved March 2, 2011 from http://www.health.gov.sk.ca/adx/aspx/adxGetMedia.aspx?DocID=1633ff92-

37fa-4ece-b798-1b8144d21420&MediaID=3712&Filename=physician-recruitment-2010.pdf&l=English

Schmidtke, O. (2006). Canada´s immigration and integration policies: A multi-national evaluation of labour market integration of skilled immigrants. Policy Memo. Victoria, BC: University of Victoria. Retrieved March 15, 2011 from http://www.carleton.ca/europecluster/Workshop-September8-2006/Memo-Schmidtke-Kovacev-Marry.pdf

Shah, Ch., & Long, M. (2007). Labour mobility and recognition of skills and qualifications: European Union and Australia/New Zealand. Working Paper No. 65. Melbourne, Victoria: Monash University. Retrieved March 18, 2011 from http://www.education.monash.edu.au/centres/ceet/docs/workingpapers/wp65shahlongmay2007.pdf

Sibbald, B. (2001). A shortage of doctors? What shortage? *Canadian Medical Association Journal*, *Vol. 164*, No. 6, pp. 857. Retrieved February 8, 2011 from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC80901/

Silversides, A. (2009). Physician mobility remains a "moving target". *Canadian Medical Association Journal*, *Vol. 181*, No. 9, pp. E191-E192. Retrieved February 15, 2011 from http://www.cmaj.ca/cgi/content/full/181/9/E191

Sinclair, S. (2007). Transforming the Agreement on Internal Trade through binding enforcement. Briefing paper, *Vol. 8*, No. 2, pp. 1-4. Retrieved March 11, 2011 from http://www.policyalternatives.ca/sites/default/files/uploads/publications/National_Office_Pubs/2007/Agreement_on_Internal_Trade.pdf

SMA (Saskatchewan Medical Association). (2009a). History of SMA. Retrieved February 17, 2011 from https://www.sma.sk.ca/Default.aspx?cid=9&lang=1

SMA (Saskatchewan Medical Association). (2009b). Mission and strategic direction. Retrieved April 4, 2011 from https://www.sma.sk.ca/Default.aspx?cid=10&lang=1

Stallknecht, K. (1992). Nursing in Europe. *British Medical Journal, Vol. 304*, pp. 561-562. Retrieved March 15, 2011 from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1881362/pdf/bmj00062-0049.pdf

Stephen, F. H., & Love, J. H. (1999). Regulation of the legal profession. Glasgow, UK: University of Strathclyde. Retrieved April 6, 2011 from http://encyclo.findlaw.com/5860book.pdf

Sullivan, P. (2008). No quick fix for wait times. *MD Pulse*, pp. 27-30. Retrieved March 11, 2011 from http://www.nationalphysiciansurvey.ca/nps/MDPulse08/10-MDPulse08_sec2-waittimes.pdf

Sullivan, P. (1999). Concerns about size of MD workforce, medicine´s future dominate CMA annual meeting. *Canadian Medical Association Journal, Vol. 161*, No. 5, pp. 561-562. Retrieved January 7, 2011 from http://www.cmaj.ca/cgi/content/full/161/5/561

Sun, V. (n.d.). CMA sends do-it-yourself medical kits to politicians. *National Post News*. Retrieved March 24, 2011 from http://www.nationalpost.com/scripts/story.html?id=f0652546-afef-4079-84c7-b9fbb1a5a454

Sweetman, A. (2005). Canada. In Jan Niessen & Yongmi Schibel (Eds.), *Immigration as a labour market strategy – European and North American perspectives*. Brussels, Belgium: Migration Policy Group. Retrieved April 17, 2011 from http://www.migpolgroup.com/public/docs/142.Canada_ImmigrationLabourMarketStrategySweetman_2005.pdf

Sylvain, M. (July 16, 2010). Internationally trained doctors and underserviced communities will be impacted by GP licensing standardization. *The Big Wait.* Reprinted from

CanadianHealthcareNetwork.ca Retrieved March 15, 2011 from http://www.thebigwait.com/international-medical-graduates/internationally-trained-doctors-and-underserviced-communities-will-be-impacted-by-gp-licencing-standardization/

The Constitution Act, 1867 (U.K.), 30 & 31 Victoria, c. 3.

Thunnissen, S. K. (2010). Labour mobility in the EU: An analysis of the barriers to the free movement of labour in the EU. Master's Thesis, University of Groningen & University of Deusto, the Netherlands. Retrieved March 2, 2011 from http://scripties.let.eldoc.ub.rug.nl/FILES/root/Master/DoorstroomMasters/Euroculture/2010/s.k.thunnissen/MA_1587110_SK_Thunnissen.pdf

Todd, J., Fabbi, F., & Sandler, P. (May 17-18, 2004). Results of competitiveness Council, Brussels. *Press Releases RAPID.* Retrieved April 19, 2011 from http://europa.eu/rapid/pressReleasesAction.do?reference=MEMO/04/117&format=HTML&aged=0&language=EN&guiLanguage=en

Torgerson, R., Wortsman, A., & McIntosh. T. (2006). Nursing skills and mobility: Facilitating the transfer and tracking of nurses across Canada. Research Report H 10. Ottawa, ON: Canadian Policy Research Network Inc. Retrieved April 18, 2011 from http://www.cprn.org/documents/43653_en.pdf

Tyrrell, L., & Dauphinee D. (1999). Task Force on Physician Supply in Canada. Canadian Medical Forum Task Force. Retrieved March 18, 2011 from http://www.physicianhr.ca/reports/PhysicianSupplyInCanada-Final1999.pdf

UEMS (Union Européenne des Médicins Spécialistes). (n.d.). Professional recognition directive – vote of the European Parliament. Retrieved February 17, 2011 from http://admin.uems.net/uploadedfiles/318.pdf

UK Office of the European Parliament. (2004). Recognition of professional qualifications: European Parliament has 1st reading on new EU directive. Retrieved March 14, 2011 from http://www.europarl.org.uk/section/2004-archive/recognition-professional-qualifications-european-parliament-has-1st-reading-new

University of Saskatchewan. (2008). Clinicians´ Assessment and Professional Enhancement (CAPE): Information for physician participants. Retrieved April 9, 2011 from http://www.usask.ca/cme/cape/CandidateInstructions2008.pdf

VanAndel, M. (2007). Summary of facts & issues pertinent to licensure of international medical graduates (IMGs) living in Canada. College of Physicians and Surgeons of British Columbia. Retrieved March 11, 2011 from https://www.cpsbc.ca/files/u1/summary-of-facts-issues.pdf

Verlander, G. (2004). Female physicians: Balancing career and family. *Academic Psychiatry, Vol. 28*, No. 4, pp. 331-336. Retrieved August 15, 2011 from http://www.med.upenn.edu/gastro/documents/AcademicPsychiatry2004_331.pdf

Vodden, C. (2008). Licentiate to heal: A history of the Medical Council of Canada. Ottawa, ON: Medical Council of Canada.

Vogel, M. (March 8, 2011). Telephone interview.

Vogel, L. (2010). Physician pool expands. *Canadian Medical Association Journal, Vol. 182*, No. 2, pp. E138-E140. Retrieved January 17, 2011 from http://www.cmaj.ca/cgi/content/full/182/2/E138

Whitaker, R. (1991). *Canadian immigration policy since confederation.* Ottawa, ON: Canadian Historical Association.

White, G. (March 18, 2011). Telephone interview.

Wojtczak, A., & Schwarz. M. R. (2006). Minimum essential requirements and standards in medical education. Institute for International Medical Education. Retrieved February 2, 2011 from http://www.iime.org/documents/vs.htm

Zong, L. (2004). International transference of human capital and occupational attainment of recent Chinese professional immigrants in Canada. *American Review of China Studies, Vol. 5*, No. 1 & 2, pp. 81-89.