**Submission to the College of Physicians and Surgeons of Ontario**

**Re. Professional responsibilities in Postgraduate Medical Education Policies**

**October 2020**

## Introduction

This is a submission by the Society for Canadians Studying Medicine Abroad (SOCASMA) to the College of Physicians and Surgeons of Ontario (CPSO) regarding the Professional Responsibilities in Postgraduate Medical Education policies which are currently being reviewed by the CPSO. We represent and advocate for Canadians who study or studied medicine in an international medical school. We also research and advocate for International Medical Graduates' (IMGs) contribution to improved access and quality of medical care for Canadians.

It is our view that, a review of the Professional Responsibilities in Postgraduate Medical Education policies must include a review of the responsibilities of the CPSO with respect to overseeing the process of residency selection and ensuring that process is legal, fair and in the public interest.

It is our submission that the CPSO must change the current residency selection process, because it excludes a sector of qualified Canadians and permanent residents from applying to most publicly funded residency positions. We seek a primarily competence-based selection process for access to residency training and thus to the medical profession.

The CPSO was provided with the power to self-regulate because the legislative model of governance determined that medical professionals are best able to determine the standards of admission and the standards of practice necessary to ensure public interest and public safety. These serious responsibilities cannot be delegated to others, and certainly not when those others use these powers to protect the interests of a select group of applicants at the expense of other qualified Canadian citizens or permanent residents. In addition, as a regulatory authority the CPSO has a gatekeeper obligation to ensure that all sectors of society have access to the medical profession based on individual knowledge, skill, and character relevant to the practice of medicine.

We respectfully submit that it is incumbent on the CPSO to use its legislative powers to take control of regulation of postgraduate medical training. We submit that any delegation of these powers to influence the selection process or criteria to favour their own graduates is inappropriate, illegal, and not in the public interest. The CPSO must recognise, and stop, the discrimination that exists in the current system of access to the medical profession which:

a. Is inconsistent with the objectives of the CPSO's empowering legislation;

b. Contravenes objectives and principles of administrative law governing regulatory authorities;

c. Contravenes the laws and public policy intended in the words of the Human Rights Code to

> "recognize the dignity and worth of every person and to provide for equal rights and opportunities without discrimination that is contrary to law, and having as its aim the creation of a climate of understanding and mutual respect for the dignity and worth of each person so that each person feels a part of the community and able to contribute fully to the development and well-being of the community and the Province."

It also contravenes the Canadian Charter of Rights and various international covenants;

d. Marginalizes International Medical Graduates (IMGs), making them second class citizens because opportunities in medicine open to their CMG peers are denied to IMGs;

e. Provides a platform from which prejudice already prevalent against IMGs continues to thrive and grow;

f. Places universities in a position of conflict of interest in which they control access to postgraduate medical training, and hence the medical profession, for the improper purpose of protecting their own graduates from competition to ensure that their graduates will become fully licensed physicians;

g. Prevents competency from being the primary residency selection criteria, thus preventing the best candidates from progressing to postgraduate training; and

h. Results in inconsistent and compromised standards of competency in the medical practice.

## **SOCASMA's Requests/Recommendations**

The purpose of this submission is to request that the CPSO:

1. Recognize that the CPSO is the only body legislatively authorized to set the standards and the qualification criteria for access to postgraduate training including residency training;

2. Set and publish all the standards and eligibility criteria that an applicant must meet to be eligible to compete for positions as a resident physician;

3. Ensure that standards and eligibility criteria be for the purpose of ensuring competence, i.e., that the applicant has the knowledge, skill, and character necessary to competently practice medicine, and for no other purpose;

4. Require uniform examinations/evaluation and timing of examinations/evaluation for all qualified candidates including CMGs, USMGs, and IMGs, including visa trainees;

5. Direct CaRMS to allow equal access to all residency positions on the same terms for all qualified graduates who are citizens or permanent residents of Canada; and

6. Oversee all aspects of entry to the medical profession to ensure admission to the profession is: (i)fair and free of discrimination, i.e., inclusive and consistent with the principles of a free and democratic society; (ii) impartial; (iii) objective; and (iv) transparent.

Please read the full submission which follows for supporting evidence, rationale and references to support our requests and recommendations above.

## Supporting Information, Rationale and References

Request 1 and 2

1. Recognize that the CPSO is the only body legislatively authorized to set the standards and the qualification criteria for access to residency training;

2. Set and publish all the standards and eligibility criteria that an applicant must meet to be eligible to compete for positions as a resident physician;

Legislators from early in our history determined that it was in the public interest for the Legislature to delegate regulation of the professions to members of the profession. This is premised on the belief that members of the profession are best positioned to determine the qualifications necessary for admission into the profession and the standards that those admitted must maintain in order to protect the public.

Because regulation of a profession has such critical impact on individuals seeking to work in the profession and on the public, the power to self-regulate is clearly defined[1]:

a. Above all the regulator must act in the public interest;

b. The public interest includes ensuring that admission to the profession is inclusive and consistent with the principles of a free and democratic society;

c. The power to regulate is to be used for the purpose for which the Legislature provided the powers to regulate, namely for the purpose of ensuring competence, and for no other purpose;

[1] https://www.hrpa.ca/Documents/Regulation/Series-on-Governance/What-it-means-to-be-regulated-profession.pdf

d. The power to set competency standards for access to the profession is for the CPSO and the CPSO only. It cannot delegate or create an environment which allows a third party to create standards of competency. If the Legislature intended another body to set standards or control aspects of access to a profession, it would have endowed that body with those powers; and

e. The regulator must meet the highest levels of accountability in its duty to act
    i. Fairly and without discrimination,
    ii. Objectively,
    iii. Impartially, and
    iv. With Transparency.

The most quoted treatise on the principles of self-regulation is Ontario's McRuer Report[2]. Excerpts from this report is attached in Appendix A at the end of this submission.

The standards set by the CPSO for certification for independent practice include:

1. A medical degree;
2. Postgraduate Training;
3. Examinations and Certification by the applicable national College;
4. CPSO review of credentials and character.

The CPSO has exercised its statutory power to set standards of competence which vary by classification https://www.ontario.ca/laws/regulation/930865 (See section 11 for regulation of postgraduate medical training). The CPSO has the right to adopt standards of other institutions and to allow others to administer its requirements. But it is not free to allow or delegate setting of standards and eligibility requirements to a third party. It cannot fetter its discretion to set standards and eligibility requirements by designating an administrator or an approved program and allowing that third party to determine the standards and eligibility requirements for a class of registrant.

Self-regulation includes the serious duty of continual oversight or "gatekeeping" to ensure that gateways to the profession are open to all those that are qualified and to all sectors of society without discrimination. The CPSO is not free to turn a blind eye to the manner in which the pre-conditions the CPSO mandated to licensing are being administered even if, as in the case of required university degrees, the university has the legislative power to set standards of admission.

[2] Ontario, Royal Commission Inquiry into Civil Rights, Commissioner: James Chalmer McRuer (Toronto: Queen's Printer, 1968-1971)

Oversight requires a review of the scope of an administrator's authority and its admission policies.

1) The Medical Degree Requirement

Both the CPSO and the Universities are created and given powers through legislation. In law they are called "creatures of statute" and are bound by the purposes and limitations of their enabling legislation.

The CPSO is given the powers it requires to regulate the medical profession in the public interest.

Universities are given powers to run academic programs. Universities are able to determine admissions standards and policies for medical school, set medical school curriculum, and confer medical degrees *because, and only because, there is legislation that gives them these powers*.

The objectives of legislation governing universities and self-regulating bodies are different.

The CPSO's empowering legislation requires it to act only in the public interest.

The legislation which empowers universities requires it to act primarily in the best interests of the university and the students.

While the university has no power to set standards or eligibility criteria to regulate admission to the medical profession, the CPSO does have indirect power over the university.

Colleges are endowed with gatekeeper powers which enable them to meet their obligations under their empowering legislation.

If a university's program is considered inadequate or if it has unfair admissions policies which frustrate the CPSO's obligations to ensure that admission to the profession is available to all sectors of society without discrimination, professional regulators have the power not to recognize that university's degrees. This is a heavy stick that the CPSO holds over the university which enables the CPSO to ensure there are no unfair barriers to any sector of society seeking to enter the medical profession.

The gatekeeper role of regulating authorities will be discussed in more detail later in this submission.

2) The Postgraduate Training Requirement

The CPSO's postgraduate training requirement is not as long-standing as the medical degree requirement. It was an evolution. The Medical Council of Canada reports that by 1952 all the provincial Colleges of Physicians and Surgeons required postgraduate training, but it was not until 1993 that the provincial Colleges determined that the university Faculties of Medicine should administer all postgraduate training. Prior to this time, there were various administrators of postgraduate training.

The postgraduate training requirement is on a different footing than the medical degree requirement in several respects:

a. The medical degree is an academic degree. Postgraduate training has an academic component, but it is in substance on-the-job training. It is mandated by medical regulators across the world for the purpose of ensuring that graduates have the necessary practical experience to ensure that they can practice safely before being licensed for independent practice. Resident physicians are employed as physicians providing necessary medical services to the public under supervision, with the degree of supervision diminishing as experience is gained.

b. Universities have the authority to set admission standards and curriculum for medical school, and to confer a medical degree. The legislative powers conferred on the universities are limited to academic education leading to academic degrees. The university being a creature of statute has no powers in respect to postgraduate medical training—no powers to set admission standards or criteria, no powers to set curriculum, and no powers to confer any certification or license.

c. The requirement of postgraduate training is a function of regulating the medical profession and ensuring public safety. Historically, the CPSO not only regulated the requirements to be eligible to compete for residency training, it also regulated the content/curriculum and duration of postgraduate training programs. With the national colleges taking on the role of accrediting postgraduate medical programs, the CPSO has reviewed and adopted those standards and as a result taken an increasingly less active role. The universities' role in postgraduate medical education is a function of the decisions and regulations of the CPSO, which have evolved and changed over time.

   The CPSO under Schedule 2 section 11 of its Regulations sets out the standards it requires for a person to be registered in the postgraduate education class. The standards and eligibility requirements include an appointment in a program at an accredited medical school in Ontario. One must assume that by "accredited medical school", the CPSO is referring to a university Faculty of Medicine accredited by either the RCPSC or CFPC to run postgraduate medical programs rather than the university Faculty of Medicine which is accredited by the LCME and CACMS to run medical school programs which lead to conference of medical degrees.

   Regulating that acceptance into a university postgraduate program be a condition of registration in the postgraduate education category is within the CPSO's powers so long as the CPSO does not allow the university to set standards for eligibility to be

considered for residency training, i.e., to be considered qualified to be registered as a resident physician.

But the CPSO has, improperly and to the public detriment, allowed the universities, and/or the Ministry of Health who together administer postgraduate training, to set the standards and requirements necessary to be eligible for consideration for postgraduate medical training. Neither of these bodies has the authority to set standards and admission criteria to a college mandated program. Neither has the authority to put in place policies and regulations which have the effect of creating unique barriers to IMGs to admission to the medical profession in Ontario.

Even if these bodies had the power to set admission standards for eligibility to be considered for residency training (which they do not), the Supreme Court of Canada has held[3] that a statutory/governmental body can only distinguish/discriminate between classes of citizens if the enabling statute expressly or implicitly authorizes such a distinction.

Only the CPSO's enabling legislation allows a distinction to be drawn between CMGs who graduate from locally accredited schools and IMGs. But that distinction must be restricted to the issue of competence. Once substantial equivalence has been established there can no longer be a foundation for distinction. As McRuer stated at page 1179:

> "The only relevant question, apart from non-educational requirements, to be asked of any applicant for admission, no matter what his place of origin and no matter where he took his training, is whether he has met the required educational standards established in the province. This question can only be answered by comparing the applicant's training with the established standards. Such an inquiry admits of only one of two possible conclusions: either the standards have been attained by the applicant or they have not."

3) Examinations and Certification by the applicable national college

The Royal College of Physicians and Surgeons of Canada (RCPSC), the College of Family Physicians of Canada (CFPC), and the Medical Council of Canada (MCC) have no legislative power to regulate the medical profession in Ontario.

All three came into existence as a function of federal legislation with defined powers.

[3] Shell Canada Products Ltd. v. Vancouver 1994 CanLII 115 (SCC), [1994] 1 SCR 231

But because the power to regulate the profession is a provincial power, these bodies and the functions they serve are relevant only because the CPSO has made them relevant through exercise of its discretionary powers. The CPSO accepted the MCC examinations through its regulatory powers as its standard. The CPSO accepted the accreditation standards and curriculum of the RCPSC and CFPC for postgraduate medical training as meeting its standard. The CPSO accepted the examinations and certifications of these national colleges as meeting its standards. These national bodies are relevant to regulation of the medical profession in Ontario because the CPSO at various points in time exercised its discretion to adopt these national standards of competence for Ontario.

To exemplify this point federal legislation created the MCC in 1902, but its current relevance came about only when every province passed legislation to approve it, and more importantly, only when the provincial Colleges agreed to recognize the Medical Council of Canada as the forum of consensus building to enable a national standard. As a result, the MCC did not create a national registry until 1912 when the last of the provinces signed enabling legislation. Even after 1912 it took a long time for the provincial Colleges to stop administering their own examinations and adopt exclusively a common national examination. At no time did the provincial Colleges lose their power to walk away and set up their own standards which are different than all the rest. In fact, on more than one occasion, the College des Medecins du Quebec went back and forth in respect to adopting the national exams.

In summary, universities administer postgraduate medical training because the CPSO decided in accordance with its broad regulatory powers to require that post graduate medical training be administered by the faculties of medicine. Royal College of Physicians and Surgeons of Canada's and the College of Family Physicians of Canada's exams, accreditation of postgraduate programs, recognized jurisdictions, and certifications are recognized because the CPSO chooses to adopt and recognize them. Similarly, with the examinations and licentiates of the Medical Council of Canada.

4) <u>CPSO review of credentials and character</u>

The final step of licensing is a final review by the CPSO to ensure that all its standards and requirements related to competence have been met by the applicant and that the applicant is of suitable character to practice medicine.

There are two important points to be gained from the above.

a. If rules or by-laws exceed the express or implied powers granted by the Legislature, they are a nullity (Regulation of Professions in Canada, Casey, p. 5-1). In this instance, nobody but the CPSO has legitimate authority to set standards necessary to be qualified to access postgraduate medical training jobs to work as resident physicians. If the Legislature had wanted the universities or the Minister of Health

to determine the qualifications to be able to compete for residency training, the Legislature would have given them that power. It did not.

b. The CPSO has no power to delegate the power to set standards. It can assign administrators and adopt standards but it cannot delegate setting standards.

**Requests 3, 4, 5, and 6**

3. Ensure that standards and eligibility criteria be for the purpose of ensuring competence, i.e., that the applicant has the knowledge, skill, and character necessary to competently practice medicine, and for no other purpose;

4. Require uniform examinations/evaluation and timing of examinations/evaluation for all qualified candidates including CMGs, USMGs, and IMGs including visa trainees;

5. Direct CaRMS to allow equal access to all residency positions on the same terms for all qualified graduates who are citizens or permanent residents of Canada; and

6. Oversee all aspects of entry to the medical profession to ensure admission to the profession is (i) fair and free of discrimination, i.e., inclusive and consistent with the principles of a free and democratic society; (ii) impartial, (iii) objective, and (iv) transparent.

As stated above, the purpose of regulation is to ensure public safety and public interest. Powers to regulate the profession are not to be used for any other purpose.

Fairness and public interest dictate that standards be directly tied to character, competence and skill of the individual, without making presumptions about any individual related to the groups to which the individual belongs or where (s)he received his/her education and/or training.

*Competence*

In its 1994 Report, the Law Reform Commission of Manitoba explained that in the public interest of being protected from improper performance of the professional service, entry standards should not contain superfluous requirements, tests must be carefully designed to correspond to the qualities needed to provide a service properly, and entry standards must be set at levels that are neither too low nor excessively high.

> "All applicants for membership in the health professions must be treated fairly and any refusal of entry into the profession must be based upon a legitimate concern about the applicant's ability to provide competent and reliable health services."[4]

Unfortunately, the CPSO's is not overseeing and controlling barriers placed before international medical graduates for improper purposes in the regulatory process. Therefore, the standards and criteria of admission to postgraduate medical training, and hence the medical profession, across Canada are not based on competence. They are based on place of education which is

[4] Canadian Health Professions, Morris, Chapter 3 pages 46-7

only supposed to be relevant until the examinations mandated to prove that IMGs meet the national standard are passed.

As a result of this abuse of purpose in the regulatory process, the purpose of the self-regulatory scheme is compromised, as is public confidence, interest, and safety.

Although all resident physicians provide the same services to the public, the level of demonstrated competence required to work as a resident physician is dependent on which group one belongs to:

a. CMGs. A CMG need only be poised to graduate from an LCME accredited school to be eligible to compete in CaRMS for a residency position.

   A CMG need not pass the MCCQE1. In fact, a CMG can fail the MCCQE1 and work as a resident physician treating patients.

   Because the number of residency positions align with the number of graduating CMGs, CMGs are practically guaranteed a resident position and thus licensure for independent practice.

b. IMGs. To be eligible to compete for a residency position, an IMG who is a citizen or permanent resident of Canada must:
   i. be poised to graduate from a FAIMER school,
   ii. pass the MCCQE1[5], and
   iii. pass the NAC OSCE[6]

   which exams are *designed to prove that one has the knowledge and skills expected of a Canadian medical school graduate*.

   Despite demonstrating that they have the knowledge and clinical skills expected of a CMG, IMGs are

   (a) denied access to the majority of residency positions, and

   (b) placed under probation in a Pre-Entry Assessment Program (PEAP) for the first 4 to 12 weeks of residency. CMGs who fail the MCCQE1 are not placed on probation; they are allowed to work as resident physicians and are practically guaranteed that they will ultimately be licensed for independent practice.

[5] The Medical Council of Canada Qualifying Examination Part 1 (MCCQE1) is designed according to the MCC to assess the critical medical knowledge and clinical decision-making ability of a candidate at a level expected of a Canadian medical school graduate.

[6] The NAC OSCE according to the MCC is "designed to evaluate an IMG's clinical skill at the level of a Canadian medical graduate entering postgraduate training."

(c) subject to sign a "return of service" contract which obligates them to work where directed by the Ministry of Health after certification for independent practice. If an IMG (who must be a Canadian citizen or permanent resident to be eligible to compete for a residency position) is successful in obtaining a residency position, unless (s)he signs the return of service contract, that position will be forfeited. CMGs are under no similar obligation. The obligation to sign these restrictive contracts arises from the fact that one is an IMG.

Only a small fraction of IMGs who apply for a residency position in Ontario and throughout Canada obtain one because IMGs are subject to a "quota", something generally reserved for products, not people[7].

c. Visa Trainees. An IMG who is a foreign visa trainee must pass the MCCQE1 to demonstrate that (s)he has the knowledge expected of a Canadian medical school graduate in Ontario[8]. There is no need to pass the NAC OSCE nor to compete in CaRMS for their positions. Their sponsor pays the university a fee and in exchange they are given a residency training position with the same responsibilities and services to the public as Canadian resident physicians.

It bears repeating that regulatory principles provide that once the national standard has been established, there can be no justification for placing additional barriers or conditions on those whose education is from another country.

Colleges have an obligation to the public to ensure that all graduates are competent before allowing them to compete for residency positions. Colleges cannot safely assume that graduates of local educational institutions meet the standards any more than they can safely make assumptions about those who are educated internationally.

Ensuring that all professional graduates meet the standard deemed necessary by the CPSO can be accomplished by administration of standardized examinations or assessments for every person seeking registration regardless of place of education.

The American system of access to postgraduate medical training is a good example of a system which evolved from substantial equivalency examinations for international graduates only to universal examinations for all graduates regardless of place of education. The USMLEs (US

[7] In 2019 there were 2302 IMG applicants who sought residency positions but only 391 IMGs received positions. Thus 1911 IMGs, i.e., 83% of IMG applicants were denied access to the medical profession in 2019. https://www.carms.ca/pdfs/2019-CaRMS-Forum-data.pdf, Slides 1 and 2. By contrast, all but 31 current year CMGs matched to residency positions at the end of the second iteration. https://www.carms.ca/news/2019-r-1-match-results-snapshot/ More were given positions after the Match. Notably, 140 CMGs failed the MCCQE1 exam.

[8] In some provinces, like British Columbia, visa trainees need not take any examinations to prove competence.

Medical Licensing Examinations) are taken by everyone seeking residency training positions in the same time frame regardless of place of education.

After the move to universal examinations, it was found that each year between 3-9% of American medical graduates failed the examinations which were designed to demonstrate that the graduate has the minimum knowledge expected of an American medical graduate.

In the Canadian system, the MCCQE1 is the examination which the CPSO deems mandatory at some point for all medical graduates regardless of place of education. As indicated above, the examination is designed to assess the critical medical knowledge and clinical decision-making ability of a candidate at a level expected of a Canadian medical school graduate. Between 3 to 5% of Canadian graduates fail this examination each year without impediment to practicing as resident physicians.

The MCCQE1 is used in a discriminatory and unfair way.

Because Canadian citizens studying medicine at an international medical school must take and pass the MCCQE1 in September of their last year of medical school to be eligible to compete for residency positions in their year of graduation, they are required to demonstrate that they have the knowledge and skills expected of a Canadian medical school graduate when they are only 75% of the way through medical school.[9]

In practice, to successfully obtain a residency position, Canadians who are IMGs must not just pass, but must perform at a superior level in the MCCQE1 otherwise their applications will usually be electronically eliminated by the universities.

By contrast, Canadian medical school students do not have to demonstrate competence by taking the MCCQE1 to be eligible to compete for residency positions. They take the MCCQE1 at the end of medical school after they have already received a residency position. Approximately 140 Canadian medical school graduates (about 5%) failed the MCCQE1[10]. Yet the CPSO allows these CMGs to enter residency training and provide medical services to the public as resident physicians despite having demonstrated that they do not have the knowledge and skill expected of a Canadian medical graduate. CMGs are obligated to pass the MCCQE1 at some point before they can be licensed for independent practice, years after IMGs are obligated to pass this examination.

As early as 1952 the Medical Council of Canada recognized that the universities were in a conflict of interest in that their allegiance was to their students as opposed to protecting the public interest. Since then things have changed: the Association of Faculties of Medicine has increased its power and control over policies related to access to residency selection; grading became pass/fail in Canadian and American medical schools, supports for weak students in

[9] In the American system, to be eligible to compete for residency training all medical students, regardless of where they are studying, take the same exams at the same time.

[10] 2018-2019 Annual report of the MCC (https://mcc.ca/media/2018-2019-Annual-Report.pdf) at page 23

medical school increased; and reluctance to fail a student increased to the point where almost no medical student is failed in a Canadian or American medical school.

The Medical Council of Canada stated in its report entitled “Recalibrating for the 21st Century: Report of the Assessment Review Task Force”, 2011 that the regulatory authorities of Canada see a need for the assessment and uniform measurement of knowledge and performance of domestic graduates and those graduating from schools accredited by the LCME. They also feel that the results of the measurement should be made available to them (page 11 of the report). At page 15 the report states that such a national process could overcome the potential conflict of interest that “universities face when trying remedial activities for the poorly performing student.”

There is no indication why the College’s do not insist that the results of the measurement be made available to them. It certainly is within their power.

The Medical Council of Canada’s and FMRAC’s voiced concerns have been successfully resisted by the universities who control access to residency training jobs despite no legitimate authority on the part of the universities to do so.

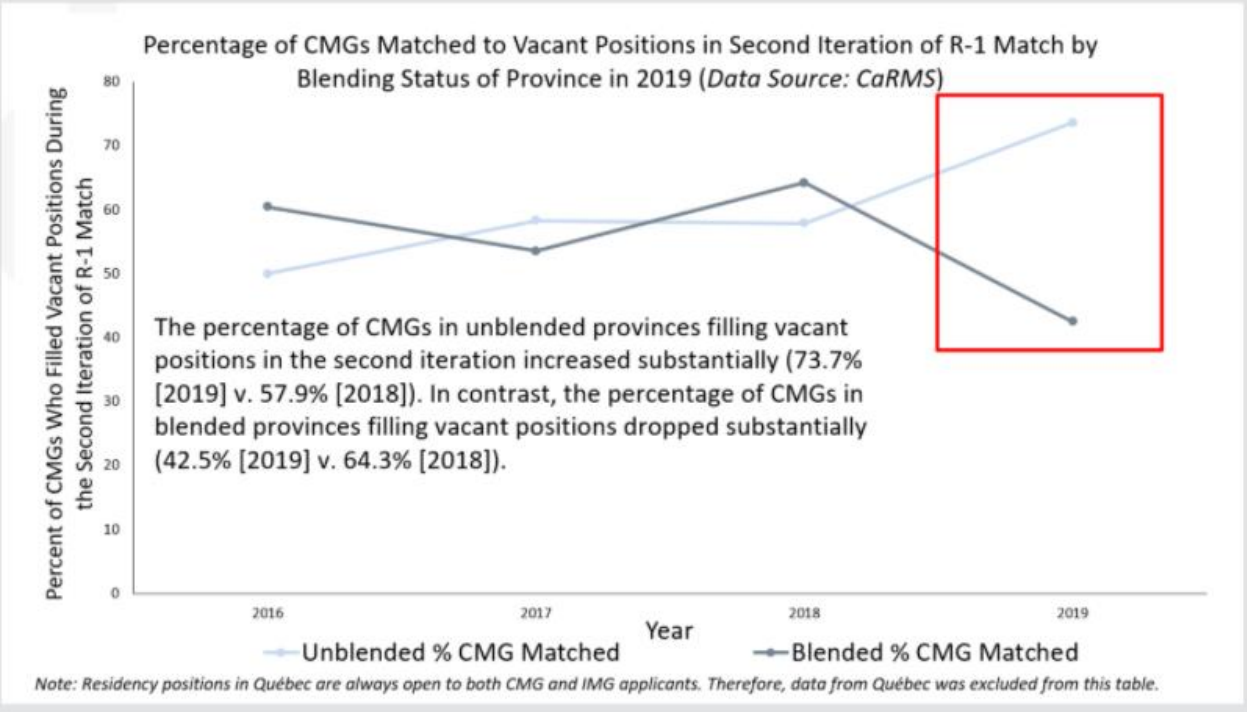
Despite the CPSO’s obligation to ensure competence, and its recognition of the fact that those in a position of conflict of interest are allowing their students and the students of their American associates to compete for and fill residency positions without establishing competence, the situation persists.

The current system of access to residency training and hence the profession is designed by universities to protect Canadian medical graduates and to ensure that every one of them obtains a residency position which then entitles them to become licensed for independent practice. This is clearly set out in the AFMC Resolution published on the CaRMS website. https://www.carms.ca/match/r-1-main-residency-match/eligibility-criteria/

The recent decision by Ontario to capitulate to the AFMC pressure to maintain segregation in the second iteration in the CaRMS Match shows both a) the objective of the AFMC is to advance protectionist/exclusionary policies in the regulation of access to the medical profession, and b) that protection tips the balance away from competence-based competition to favour CMGs. Below are excerpts from the AFMC Newsletter dated November 19, 2019 that present both points clearly.

## The Impacts of Unblending during the R1 Match

In 2018, AFMC released a report with recommendations to address the increasing number of unmatched Canadian medical school graduates. AFMC advocated that provincial governments keep funding streams for Canadian medical graduate (CMG) and International medical graduate (IMG) streams separate during the second iteration of the match (unblending). For the 2019 R-1 Match, Ontario, Manitoba and Alberta changed their policy. As a result, the percentage of CMGs in unblended provinces filling vacant positions in the second iteration increased substantially. For this reason, AFMC will continue to recommend that all provincial governments unblend the second iteration of the R1 match to reduce the number of unmatched CMGs.




This graph demonstrates the impact on competence of segregation and protection from competition in the second iteration. In the provinces where CMGs are protected from competition against IMGs, the CMG rate of matching increased from 57.9% to 73.7%. But in the provinces where CMGs and IMGs competed against each other, the percentage of CMGs who matched was reduced to 42.5%. It is for this reason that the AFMC will continue to recommend higher protectionist policies, to ensure that less competent CMGs displace more competent IMGs so that fewer CMGs go unmatched.

It is also for this reason that the CPSO must act to restore the public interest in terms of access to the most competent physicians. How can any fair, principled regulatory system allow this to happen?

This is a clear breach of regulatory legislation where regulation is to be used to ensure competence and for no other purpose. It is a clear breach of the principle of equality upon which Canada is founded when something as fundamental as access to education/training and a profession is protected for one sector of Canadian society (Canadian and American medical

school graduates) to the detriment of another sector of Canadian society (Canadians who chose to study medicine outside Canada and the USA and immigrant physicians). The clarity of second-class status of Canadians who are IMGs is apparent in:

(a) protectionist policies which limit their ability to compete against other Canadians for residency positions and hence access to the medical profession on the basis of individual knowledge, skill, and character; and
(b) the imposition of return of service contracts upon every IMG as a condition of accessing residency training, even after overcoming the higher competency standards, the limited number of positions, and the prejudice that IMGs face.

The graduation and promotion of low competency medical graduates is a concern in both Canada and the United States. These to the best of our knowledge are the only two countries where the universities control and administer postgraduate medical training. To our knowledge, in all other countries the regulating authorities retain complete control of postgraduate medical training.

The New England Journal of Medicine in December of 2019 sets out the various factors that push graduation of weak medical students. The authors summarize the problem in the following terms:

> "Every spring, U.S. medical schools graduate some students who should not be allowed to become doctors. Despite multiple incentives for promoting, and barriers to dismissing, problematic students, medical schools have a responsibility to patients and the profession." "Kicking the Can Down the Road — When Medical Schools Fail to Self-Regulate", Santen, Christner, Mejicano, and Hemphill, N Engl J Med 2019; 381:2287-2289

Such policies and practices on the part of universities ultimately become the problem and responsibility of the CPSO when these incompetent or poorly prepared physicians come before the College's ICRC and Disciplinary Committees. The "Right Touch" risk management approach suggests that it is incumbent upon medical regulators such as the CPSO to address this concern prior to these weak and even incompetent physicians entering residency training where they can injure patients. In order to address this issue and manage this risk, it is necessary for CPSO to assert its regulatory powers to move toward a competence-based model of residency selection and entry to practice.

The legislation which empowers universities in Ontario does not expressly provide a duty to patients and the profession as suggested in this American publication.[11] The universities' lack of legislative duty to patients and profession is inconsequential in other professions because no regulatory authority other than the CPSO allows the universities to control admission to postgraduate professional training (and hence the profession). But there are harmful

[11] Legislation empowering academic institutions across Canada, generally provide that the university's obligation is to act in the best interests of the university and its students.

consequences that flow from the CPSO's failure to control access to the medical profession by allowing a university to set up barriers which exclude and hinder international graduates and set out to create significant advantages and lower standards for its graduates and the graduates of its American university associates.

American graduates, like Canadian graduates are not tested for competence as a condition of access to residency training positions in Canada. Clearly, requiring Canadian and American medical school graduates to take a universal examination would be disadvantageous to them as it would (a) disqualify those who do not pass the examinations, and (b) would provide a common platform from which programs could actually determine who is in fact, "the best and the brightest" rather than promoting the prejudice that CMGs are superior to IMGs.

*Discrimination*

Pursuant to the principles of administrative law, the government has a positive duty to ensure that no Canadian faces discrimination in government policy except as expressly permitted by legislation.

Regulations or government policies which "give permission to one and refuse it to another" are discriminatory in administrative law and illegal.

"Discrimination ... means practices or attitudes that have, whether by design or impact, the effect of limiting an individual's or a group's right to the opportunities generally available because of attributed rather than actual characteristics ..."[12]

Discrimination analysis requires a substantive equality approach that examines the effects of licensing requirements. Discrimination is a question of adverse effects rather than a question merely of form or intention.

It is not relevant that the CPSO does not intend to empower the AFMC and the universities to discriminate against IMGs. There is a positive duty on the CPSO to ensure that access to the profession is not impeded at any stage by discrimination:

- Elimination of discrimination is in the public interest.
- Licensing practices of professional regulatory bodies are subject to the requirements of equality and non-discrimination norms and must be consistent with human rights norms.
- There is a public interest in the removal of discriminatory barriers to entrance to the professions that includes both an interest in equality of opportunity with respect to employment, and an interest in access to non-discriminatory public services.

[12] Action Travail des Femmes v. Canadian National Railway Co., 1987 CanLII 109 (SCC), [1987] 1 S.C.R. 1114 citing Abella Report on equality in employment (pages 1138-9);

Many reports and studies verify the existence of prejudice, exclusion, and marginalization of international graduates in accessing professions, especially in the medical profession where discrimination is patent and institutionalized.[13]

There can be no issue that the system of regulation of the medical profession involves institutionalized discrimination against IMGs which prevents the majority from becoming licensed. Specifically, IMGs in Ontario and throughout Canada are:

a. Limited to a small number of residency positions in comparison to their CMG counterparts (0.16 position per IMG applicant versus 1.16 positions per CMG applicant in Canada);

b. Denied the opportunity to compete for residency positions in the majority of recognized disciplines in most provinces;

c. Forced to sign what are euphemistically called "return of service contracts" as a condition of having access to residency training. This is a strong and uncontroverted marker of exclusion and marginalization of IMGs in the medical profession, and ironic, as it is the CMGs whose education is heavily subsidized by the Ontario taxpayer, not the IMGs'. If return of service contracts were appropriate for the opportunity of accessing a training job, wouldn't fairness require that CMGs also be liable for return of service?

d. Required to pass the MCCQE1 and the NAC OSCE to be allowed to compete for residency positions and only a few IMGs with outstanding scores will get a residency position. By contrast CMGs take the MCCQE1 examination after securing a residency position, and are allowed to work as resident physician even if they fail the MCCQE1. CMGs do not have to take the NAC OSCE at all.

e. Subject to a probationary period (Pre-Entry Assessment Program) by the CPSO despite having proven substantial equivalency by passing the MCCQE1 and NAC

[13] "Solutions for access: A report on the access to licensure in regulated professions for internationally trained professionals in British Columbia", MOSAIC, 2006 https://www.mosaicbc.org/wp-content/uploads/2017/01/Improving-Access-to-Licensure.pdf
"Report on Removing Barriers for International Medical Doctors" Prepared for the Minister of Health and Long Term Care of Ontario, 2008 https://muskoka.civicweb.net/document/22588
"The underutilization of international medical graduates in Ontario and Canada: A selective review of the existing literature on the experiences of international medical graduates in the context of Canadian health care policies", Sahar Taghizadegan, 2013, Immigration and Settlement Studies, Ryerson University
"Moving beyond orientations: a multiple case study of the residency experiences of Canadian-born and immigrant international medical graduates" Umberin Najeeb https://www.ncbi.nlm.nih.gov/pubmed/30259266

OSCE exams. By contrast, the CPSO does not impose probation on CMGs, not even on those who fail the MCCQE1. CMGs are supported until they complete the program, while IMGs are readily removed.

These discriminatory working conditions lead some members of the public to assume that the barriers to IMGs are a function of IMGs' inferiority as the average Canadian would not conceive that this type of systemic governmental discrimination could exist in the context of Canadian laws and values without a concern about competency.

The systemic discrimination also gives rise to data which "support" and feed the prejudice against international medical graduates. Data will demonstrate that on average Canadian medical school graduates do better in the MCCQE1 than international graduates, but few people will realize that Canadians studying at international schools must take the exam one year prior to graduation while Canadian medical school students take it at the end of medical school and in the case of those who fail during their residency program.

We encourage the CPSO to show leadership by enacting regulations which require universal competence and force the elimination of the unjust discrimination that IMGs face.

*Oversight/Gatekeeper Role*

The CPSO like every other professional regulator in Canada has a positive duty to oversee that administrators of pre-conditions or programs it mandates are (consistent with the purposes for which regulation of the profession exists (competency/public safety) and that the university or other administrator is not creating barriers that are contrary to human rights values and principles of fundamental justice.

The need for this gatekeeper power is self-evident: If universities or other administrators of programs which are necessary for admission to the profession have discriminatory and other unfair practices, it has the same exclusionary effect as if the CPSO itself discriminated: the sector of the population which faces that discrimination will be unable to access the profession.

Even when the university has legislative powers to determine standards to a CPSO mandated condition such as a medical degree, if the university has discriminatory policies that prevent or impede a sector of society from accessing medical school and hence the medical profession, there is a positive duty on the CPSO to exercise its discretion not to recognize that degree.

The jurisdiction of a regulatory body to consider human rights values in the approval of educational programs is well established.[14] The power of a regulatory authority to establish standards includes the need to ensure that "fulfilment of public functions is undertaken in a manner that does not undermine public trust and confidence". Schools are "meant to develop

[14] Trinity Western University v. College of Teachers (British Columbia) 2001, 199 DLR (4th) (SCC)

civic virtue and responsible citizenship, to educate in an environment free of bias, prejudice, and intolerance."

This issue was litigated in Ontario recently when a Christian university in British Columbia set up admission criteria that indirectly prevented gay people from applying to its law school. Although the Law Society in Ontario has no jurisdiction to interfere with Trinity Western's admission policy which discriminates against gay people, it did have the power not to recognize law degrees conferred by that university as part of its gatekeeper function[15].

All professional regulatory bodies must be vigilant gatekeepers of the educators and administrators of programs they mandate as a condition of registration to ensure that individuals are not hindered in accessing the profession due to discrimination and contravention of public policy, legislation, and covenants established to protect equal opportunity based on individual merit including:

a. The Human Rights Code which succinctly sets out human rights values and public policy including respect for all members of Canadian society.

b. The Canadian Charter of Rights which expressly protects:
    i. Freedom;
    ii. Equality; and
    iii. Mobility.

c. International Treaties such as:
    i. United Nations Declaration of Human Rights and in particular sections 22, 23, and 26 which require non-discriminatory, merit-based advancement.

    ii. Lisbon Recognition Convention. "The purpose of the LRC is to facilitate the mobility of individuals through the recognition of academic credentials issued in and outside Canada, and to improve access by other countries and individuals to information about the education systems in Canada."

    iii. International Covenant on Economic, Social and Cultural Rights which sets out to guarantee equal access to education and work for all individuals.

    iv. International Covenant on Civil and Political Rights which sets out to guarantee freedom, equality and mobility for all individuals.

    v. Convention relating to the status of Refugees (the "Refugee Convention"). This convention provides that if a person is denied access to

[15] Trinity Western University v. Law Society of Upper Canada, 2018 SCC 33 (CanLII), [2018] 2 SCR 453 https://www.canlii.org/en/ca/scc/doc/2018/2018scc33/2018scc33.html3

education or to practice a profession in keeping with their education in their country, then that person meets the definition of a refugee within Canadian law. It is hypocritical that we as a nation will grant international graduates refugee status on this basis and then prevent them and our own citizens and permanent residents from practicing in the medical profession through a myriad of regulatory obstacles.

## Appendix A: Excerpts from McRuer Royal Commission Reports.[16]

In the 1960s and 1970s, the question arose across Canada, whether the rights of individuals were adequately protected in the self-governing model. As a result, commissions were established to study this issue across the country. The McRuer Commission's findings have often been quoted in authoritative literature and in the courts, including the Supreme Court of Canada.

The McRuer Commission sums up the responsibility in the following terms:

> "The power of self-government is essentially the power to decide who shall be permitted to earn his living by the pursuit of a particular calling." (p. 1163 of the report. Quoted in Regulations of Professions in Canada, Casey. Page 1-1.)

The McRuer conclusion was that self-regulation was a viable model but that there must be vigilance in respect to the following:

a. The primary purpose of a self-regulating authority is the protection of the public;
b. Members of the profession have an interest in ensuring that the profession is operating in accord with public interest and that the public perceives this to be the case; and
c. The importance of *proper* regulation cannot be overstated as it is vital to the public safety and interest. This includes fairness of access to and continued membership in the profession because work is so important to the individual and to the functioning of society and the principles upon which society is based.

The McRuer Royal Commission Report's description of the public interest in the admission of candidates into a profession:

> "We have made it clear that the power to admit a licensee is not conferred to protect the economic welfare of the profession or occupation. Those professions or occupations which have been granted self-governing status are charged with a responsibility not only to see that persons licensed are qualified, but that all qualified applicants are licensed. The public has a genuine and very real interest in knowing that the members of the self-governing bodies are properly trained and have good ethical standards. The technical nature of the services performed by the members of such bodies makes it very difficult for the layman to assess the competence of the practitioner and gauge the value of the services he has received. The public must be able to rely on the judgment of those who are empowered to decide that persons licensed to practise a profession or engage in a self-governing occupation are qualified. That being so, the responsible and experienced members of a profession or occupation

[16] Ontario, Royal Commission Inquiry into Civil Rights, Commissioner: James Chalmer McRuer (Toronto: Queen's Printer, 1968-1971)

> on whom the power of self-government is conferred should be in the best position to set the standards to be met and the qualifications of anyone who aspires to enter the profession or occupation. But it must be recognized that each of the self-governing bodies has been given a statutory monopoly through its licensing powers. What has to be guarded against is the use of the power to license for purposes other than establishing and preserving standards of character, competence and skill." (Emphasis added.)

Thus, the purpose of the delegation of the power to license is to establish and preserve the standards of:

a. Character;
b. Competence; and
c. Skill.

The use of the power to license for any other purpose must be guarded against. Subject to principles of administrative fairness, the protection of other interests is not to be tolerated.

In respect to societal inclusion, McRuer gives the example of the requirement of a degree equal to University of Toronto's degree in pharmacy. To meet this requirement, it is not necessary to have a degree from the University of Toronto; one may prove the requisite knowledge by passing the examinations required by the regulatory body. P. 1179

> "Questions of immigration are entirely separate from the exercise of powers conferred on self-governing bodies. The only relevant question, apart from non-educational requirements, to be asked of any applicant for admission, no matter what his place of origin and no matter where he took his training, is whether he has met the required educational standards established in the province. This question can only be answered by comparing the applicant's training with the established standards. Such an inquiry admits of only one of two possible conclusions: either the standards have been attained by the applicant or they have not." Emphasis added.

At page 1174 the McRuer Commission gives an example of attempts to limit the numbers of people from other jurisdictions being admitted into the profession. The Commission underscores that this is outside the objectives of regulatory legislation:

> "Under the regulations passed under the Pharmacy Act, applicants for registration who have qualified outside Ontario shall not be registered in Ontario in numbers exceeding one per cent of the total registered membership of Pharmaceutical Chemists in Ontario in the same year. These restrictions serve to alert the public that the power of self-government has real monopolistic attributes."
>
> "In any case, there should be adequate safeguards against standards of admission being employed as regulatory devices to limit the number of those entering the profession or occupation."

At page 1184, the McRuer Commission speaks out against provinces entering into reciprocal arrangements with others which have the effect of excluding qualified applicants:

> "It is recommended that there should be no legislative recognition of a power to exclude qualified applicants for admission who come from outside the Province on any principle dependent on reciprocal arrangements."