Dear Mr. Adams and Dr. Buchman,

Thank you for your response. I am sure that you appreciate that the response does not address our concerns. Nor does it address the fact that the current system of access to residency training and hence the medical profession is inconsistent with the CMA’s Equity and Diversity in Medicine policy.

I am familiar with the CMA’s policy document “Flexibility in Medical Training” which was produced in 2009. We agree and support the problems identified in that document and the need to address them. The problems sought to be addressed arose at the same time as the policy to prevent international medical graduates who are citizens and permanent residents of Canada from competing for entry to medicine jobs on the basis of individual competence. It was 1993. This was when interning was abolished and the Colleges of each province gave the Faculties of Medicine a monopoly over administration over postgraduate education. The faculties of medicine immediately used their position to further their own interests.

The College had, and continues to have, a positive duty to ensure that the regulation of the profession is in accordance with their empowering legislation, administrative law principles applicable to self-regulation, the human rights code, and the Charter of Rights. They failed in that duty. They effectively, whether intentionally or not, delegated their powers to control access to the profession to the Faculties of Medicine in their province who act in consortium with others to do what from their lens is best for the profession. As a result, we now have a system of access to the medical profession which is run for the benefit and efficiency of the Faculties of medicine and the Ministries of Health. This failure to control regulation by the Colleges compromises the public interest and

1. the standards required to enter the medical profession as a resident physician. There are three standards depending on which class of person you fall into—graduate of a Canadian or American medical school, international medical graduate who is a Canadian citizen or permanent resident, or international medical graduate from a Gulf state whose sponsor provides financial incentives to the Faculties of Medicine and the Ministries of Health;
2. the quality of medical practice. The quality is compromised firstly, by failing to allow open competition into entry level jobs which would select the best candidates for advancement to full licensure. Secondly, quality is compromised for all the reasons set out in “Flexibility in Medical Training” which reflects restrictions that interfere with the profession’s ability to pursue competence and excellence in medicine, including the freedom to make informed decisions, to change paths, and to develop and pursue different interests in medicine;
3. the principles of a free and inclusive society and the law that protect it. The legislation which empowers self-regulating bodies is carefully engineered to avoid as much as possible a conflict of interest. Regulation is to be used for one purpose and one purpose only, competence. Regulation is to be structured to ensure societal inclusivity and to impede the freedom of individuals as much as possible. Regulation certainly is not intended to allow an institution to use an administrative position for its own purposes which brings us back to the British class system where to advance in one’s profession one must have attended the right school and have the right associates.

I have repeatedly asked those in the medical establishment by what legal authority the Faculties of Medicine who are creatures of statute make the rules which have these deleterious effects on medical graduates, the profession, and the public? Nobody seems interested in asking the question, let alone providing the answer. Based on my legal research, there is no legal authority by which they can do what they are doing.

The Faculties of Medicine for 27 years have been allowed to regulate the profession, and set up barriers contrary to the public’s and profession’s interest with little to no interference by the Colleges, to the point where a culture has developed that makes organizations and people in the medical profession blind to the root cause which compromises standards and individual freedom in medicine, injustice, marginalization, and the rule of law. I have concluded on the basis of our research that the impact of fear of speaking out, conformity, and self-interest are large drivers in the medical profession which likely account for the failure of medicine to develop in accordance with legal principles relevant to regulated professions.

When we spoke, I was confident that both of you understood how the current system of access to the medical profession is inconsistent with CMA’s Equity and Diversity in Medicine policy. I could feel your discomfort. It was evident that you recognized the injustice of the situation, but that this was a situation that would be uncomfortable to align with the Equity and Diversity policy because many’ if not the majority, of your members have been so encultured by their education at Canadian and American medical schools which engrains the “fact” that CMGs are entitled to become physicians while other Canadians who are international medical graduates are not; and that CMGs are superior to IMGs and more suitable for practice in Canada.

The justifications are numerous and all flawed, but powerful. Of course, restricting IMGs to a small proportion of seats that allow access to the medical profession assists in perpetuating this culture.

You quoted from “Flexibility in Medical Training”:

“*It is necessary to provide IMGs with a reasonable opportunity to attain their postgraduate credentials and become licensed to practise in Canada. This reflects the CMA’s recognition of the important contribution that IMGs have made, and continue to make, in the provision of medical services, teaching and research in Canada. Opportunities for IMGs will also permit Canadians who study medicine abroad to pursue their medical careers in Canada.”*

I am sure that you appreciate that this quotation contravenes the CMA’s Equity and Diversity in Medicine policy. IMGs who are Canadians under the Equity and Diversity policy are entitled to “an equal opportunity” to attain their postgraduate credentials and become licensed to practise in Canada, not a “reasonable opportunity”. A “reasonable opportunity” imports judgment which in the current culture ensures that CMGs remain “recognized” as more worthy of access to medicine in Canada--even when they fail the MCCQE1 examination in which IMGs must excel to have any “reasonable” opportunity to practice medicine in Canada.

Implicit in the “recognition of the important contribution that IMGs have made…” is that there is a difference in the contribution of IMGs compared to others. This statement is evidence that the 2009 policy reflected that IMGs stand apart from CMGs and are not equal. This saddles every IMG with group characteristics and the assumptions and characterizations made about that group.

Sadly, since at least 1993 it is true, newly admitted IMGs’ contribution has largely been restricted to underserviced disciplines. It is convenient for society to have a subservient group to fill services and regions, the privileged do not fill.

I cannot tell you how many times I have been told that CSAs are welcome and wanted in British Columbia, even when it was impossible for a CSA to get a residency position in BC in the year of graduation. When someone feels that there is a need to tell someone that they are welcome and wanted in their own country and that there are “opportunities for IMGs” which “permit” them “to pursue their medical careers in Canada”, “they” would be culturally insensitive not to recognize that the speaker has put “them” on a lower platform and they are neither welcome nor wanted—at least not as equals.

We are aware of who determines who should take the NAC OSCE. Although it legally should be the Colleges of the provinces, in fact it is the Faculties of Medicine and Ministries of Health who make that determination. The NAC OSCE was mandated as necessary by UBC and the Ministry of Health (neither of whom has legal authority to mandate it) years before it became mandatory in 2015 in the other provinces.

The purpose of our June 16, 2020 correspondence was to ask the CMA to take action and to work with us to make the Equity and Diversity in Medicine a policy of substance and universal application in medicine, rather than a feel-good statement for those who support actively, or by lack of action, a policy of discrimination where IMGs are treated as less worthy than CMGs of access to the profession. In these times of Black Lives Matter every Canadian wants to believe that (s)he supports a fair, inclusive society. Of course, refusing to allow IMGs to compete on the basis of individual merit is not that ugly word “discriminatory” in the minds of CMA members if they “know” that Canadians who are IMGs are inferior and less worthy. After all, everyone has had an experience with at least one IMG who was substandard which proves the point of IMG inferiority. Sure, there are CMGs who are substandard, but that is different--all CMGs cannot be judged by the bad apples because that would be unfair.

You write, “In closing, the CMA will continue to advocate for expanded capacity and flexibility in the postgraduate training system.”

I expect that you are aware that advocacy for expanded capacity has been successful. Between 2013 and 2020 there has been an increase of 136 residency positions across Canada. CMG positions have been increased by 159 and IMG positions have been decreased by 23. [https://www.carms.ca/pdfs/2020-carms-forum.pdf](https://www.carms.ca/pdfs/2020-carms-forum.pdf%20)  Slide 8. Newfoundland currently has zero positions allocated to IMGs.

In our discussion of July 3, 2020, I was advised that our correspondence and the issues it addresses would be taken to the leadership team.

I have four questions:

1. Has our correspondence and the issues it raises been taken to the leadership team?
2. If so, was a ruling made and what was it?
3. Am I correct in understanding that the CMA is satisfied that IMGs should remain segregated from CMGs so that entry level positions to the medical profession are protected for CMGs, and that the CMA will simply advocate for expanded capacity and flexibility in the postgraduate training without regard to (a) how the treatment of IMGs in the medical profession aligns with CMA’s Equity and Diversity policy, and (b) the reality that new positions have all been allocated to CMGs plus 23 IMG positions have been shifted to CMGs?
4. I contacted the CMAJ to obtain the opportunity to write about this issue. I received no response. Is it possible for the CMA to facilitate the CMAJ allowing us to publish on this issue of the disparity between policy and practice so that the deculturalization and conversation of CMG privilege and IMG inferiority can begin?

I look forward to your response.

Rosemary Pawliuk

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