To: Society of Canadians Studying Medicine Abroad (SOCASMA)

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I. Introduction

Canada's healthcare system is extremely reliant on internationally-trained doctors: about a quarter of our current physician workforce are graduates of international medical schools (about 25,000 out of 97,000).[1] [2] On the other hand, these physicians face numerous obstacles obtaining licensure in Canada, with no guarantee of success, leading to an untapped domestic resource of unlicensed and unemployed physicians[3] and an exodus of potential Canadian doctors who opt for better chances elsewhere.

Improving the domestic training and career prospects of Canadian students studying medicine abroad is one among many possible partial solutions to Canada's physician shortage. These students have legal status to study and work in Canada, have ties to local communities, tend to be strongly motivated to return to and practice in Canada, are native English and/or French speakers, and have trained at accredited, internationally recognized medical schools. Removing inequitable policy and regulatory barriers for this group should be a priority for post-graduate training programs, licensing authorities, and provincial and territorial governments.

By coincidence Health Canada just released a study of healthcare human resources. [4] They found a current gap of 23,000 family physicians in Canada. Our current rate of training increases our supply by less than 2% per year, an amount which will never get us close to our needs. The report suggests immediate and aggressive reform of our approach to training physicians. Also of concern is the expected shortfall in the United States, which could be 124,000 physicians short by 2034. It is expected that Canadians trained at home or abroad will be incentivized to fill some of this gap

II. Who Are the Players?

Medical School Graduates

Canadian Medical Graduates (CMGs) are Canadian citizens or permanent residents who have graduated from a Canadian medical school.

International Medical Graduates (IMGs) are all other doctors, regardless of citizenship or residency status, who graduated from medical schools outside of Canada.

Canadian Students Studying Medicine Abroad (CSAs) are Canadians who trained abroad and graduated from medical schools outside of Canada. It is how this group are treated within the Canadian medical system on return to Canada that is the focus of this report.

Institutions and Programs

Association of Faculties of Medicine of Canada (AFMC)[5] is the partnership of Canadian faculties of medicine that oversees undergraduate and postgraduate medical education.

Medical Council of Canada (MCC)[6] sets a minimum competency exam usually required to enter practice as a physician in Canada.

Canadian Resident Matching Service (CaRMS)[7] generates an algorithmic match of applicants with post-graduate (residency) training positions across Canada.

College of Family Physicians of Canada (CFPC)[8] certifies Family Physicians and their training programs in Canada.

Royal College of Physicians and Surgeons of Canada (RCPSC)[9] certifies all other Canadian specialist physicians and their training programs.

Provincial and Territorial Colleges of Physicians and Surgeons (e.g. CPSBC[10]) are the licensing and regulatory authorities in each province.[11] They set standards for licensing within the province, including licensing required for post-graduate medical education.

II. Context: Canada's Physician Workforce

Current Physician Shortages

Past and recent debates concerned whether we have an adequate supply of physicians for our population.[12] In the opinion of many, we do not.[13] Many surveys suggest a significant percentage of Canadians have no access to primary care, whether a family physician or any other source.[14] This is often used as an argument for a variety of interventions, including: increasing fee income;[15] more aggressive recruiting;[16] and possibly even training more physicians.[17]

The issue is obviously related to the number of physicians we produce domestically. Canada produces only 7.5 new medical graduates annually per 100,000 population—barely half the OECD average of 14.2 per 100,000.[18] In terms of active physicians per capita, Canada ranks 27th out of 37 comparator countries.[19]

There is no inherent reason Canada does not train more physicians. The truth is, however, that as a country we have been able to rely on internationally trained graduates to provide a quarter of our physician workforce.[20] We take many of these physicians from countries that are even less well-resourced than our own,[21] which can be seen as predatory.[22] Canada benefits from this arrangement at the expense of other countries' educational investments.

Historical Context: How did we get to such a marginal supply?

The history of this scenario starts many years ago, but most recently the biggest impact was in 1992, when the provincial governments responded to a 1991 report suggesting that Canada was producing too many physicians.[23] Provincial governments took this as fiscal good news and immediately cut medical school seats and residency positions by 10%.[24] Even later, as medical school class size increased, the number of sites for residency training did not keep up .[25]

In further response to this, the federal government, seeing that it could now reduce health transfer payments significantly, did exactly that.[26] As a result, there has been sluggish growth in health care spending for some time.

Although some initiatives to increase undergraduate training have been announced, the big picture will likely not improve. Surveys of physicians have suggested a significant number, because of current stresses, are considering retirement or relocation.[27] [28] Governments have treated this, in some cases, as an idle threat.[29]

III: Context: Canada's Medical Training System

For context, we will discuss the typical path of a Canadian-trained physician (CMG) and thereafter compare where the barriers lie for IMGs and CSAs. This comparison is important because students who are denied admission to a Canadian medical school and may choose to study abroad. However, such a denial alone should not be seen as an indicator of their suitability for future residency acceptance or practice in Canada.

Getting into Medical School

The Canadian medical school admissions process is among the most competitive in the world, by virtue of the large number of qualified applicants relative to an extremely limited number of seats. The admissions requirements are stringent.[30] Canada's undergraduate universities produce thousands of qualified applicants annually; in 2022 14,672 applicants submitted 29,810 applications for approximately 2500 places.[31] In other words, each applicant had a 17% chance of getting into a medical school. In comparison, in 2023, only 52,577 people applied to American MD-granting schools, of which 43% matriculated.[32]

Intense competition has led to inflation of *de facto* admission requirements. For example, the University of Toronto Faculty of Medicine requires a minimum 3.6 GPA for admission; their incoming class in 2024 had an average GPA of 3.95.[33] Approximately 20% of incoming medical students have Masters degrees or higher, and the average age at acceptance has also crept up as more people require multiple application cycles and more impressive CVs to compete.

In more recent years, a deeper and broader view has been adopted. Medical schools have attempted to make their application assessment more "holistic," expecting thousands of hours of unpaid research, volunteer, and extracurricular activities[34] to demonstrate the student's maturity, commitment, and well-roundedness. This approach has been criticized as disadvantageous to those who cannot afford elite "volunteering" opportunities[35] or have few social connections in the profession.[36] Schools employ a standardized "situational judgement test" that aims to quantify "social intelligence and professionalism, like ethics, empathy, problem-solving and collaboration."[37] In addition, many Canadian medical schools have attempted to "level the playing field" for equity-deserving groups, for example, through Indigenous student admission pathways, but regardless, competition for all seats remains extremely intense.

Matching to a Post-Graduate Residency Training Program

The CaRMS-run residency match is a process unchanged for many years, despite criticisms.[38] [39]

Those interviewing and ranking candidates admit that they are doing so with very little information.[40 41] Selection committees do not know how well the student did academically in medical school, since there are no marks other than "pass" or "fail" from our own medical schools. The results of the final-year MCCQE (see next section) are not available at the time of the match for most students, and so cannot be assessed competitively. This is in contrast to the matching program in the United States, where their most discriminating standardized exam, the USMLE step 2, is taken before the match and is correlated with success in matching to competitive residency streams.[42]

So, what are residency selection committees looking for? How to determine something as ill-defined as the "fit" of an applicant for the intended program? Are they looking for somebody who just resembles their current trainees or even themselves?[43 44] Selection committees may be swayed by letters of reference from influential members of their university or specialty, potentially perpetuating the advantages of those students who have already established favorable connections within the discipline.[45]

Do selection committees just try to avoid anyone who may be troublesome or more difficult to train? Is this in any way objective? A few years ago, an applicant had been formally accepted but was then later dropped due to undisclosed personal matters which had no connection to his professional practice.[46] The university simply did not want to have to be of any assistance if problems arose later.

Programs usually receive many more applications than there are positions available (each CMG submits an average of 20+ applications).[47] Many selection committees, faced with dozens of nearly indistinguishable applications, rely heavily on the interview process despite mixed evidence that it is of value in predicting resident success.[48] Ideas for blinding the process have been proposed, but it is hard to imagine this becoming widely accepted.[49]

All parties to the match know that there will be some level of bias. Home institution bias is frequent[50] and is usually not considered discriminatory in an unethical or illegal sense. Residency programs, for example, may assume that an applicant from a distant part of the country is more likely to want to match closer to their own home. The notion of subconscious bias has also been identified. Termed "taste-based discrimination," it arises from a negative "first impression," which still influences judgment.

Although the CaRMS algorithm itself is "unbiased" in the sense that it is designed to make the closest fit between applicants' rank-order lists and programs' rank-order lists, the lists themselves are subject to input bias.

Becoming a Licentiate of the Medical Council of Canada

Canadian medical school graduates take the Medical Council of Canada Qualifying Exam (MCCQE)[51] at the end of medical school, almost invariably after having been matched to a residency program. This is a multiple-choice examination covering a full range of medical topics organized around the Canadian Royal College's CanMEDS roles.[52] A small number of Canadian-trained medical students do fail the exam.[53] Still, final year CMGs are well-poised to attempt the exam; they have the benefit of currency of their medical school curriculum. But IMGs originally trained and practicing in a specialty will find many topics will inevitably fade from memory. In addition, Canadian medical schools, well aware of the MCCQE requirements, will tend to ensure that all their candidates will have a good exposure to these topics in their curriculum, and some schools run dedicated MCCQE examination preparation and review blocks.[54] Although the practice is disavowed by medical schools and students alike, access to informal resources like "recall" question banks gleaned from past years' students is an open secret that further benefits CMGs.

CMGs are generally eligible to receive the designation "Licentiate of the Medical Council of Canada" (LMCC) after passing the MCCQE and completing one year of post-graduate training in Canada.[55] The LMCC is part of the requirements set out in most provinces for eligibility for licensure going forward. Interestingly, there seems to be no time limit on this credential. A pass even 40 or 50 years ago will still count.

III. Challenges faced by CSAs

Misconceptions and bias

We should address a common misconception. Canadians who choose to go abroad to study medicine are not "less than" or "subpar" to those who gain acceptance to a Canadian school. They are not even necessarily people who have tried and failed to secure a Canadian seat. As the discussion above has made clear, there are not enough training spots in Canadian medical schools to: 1) meet the workforce demands of the system; or 2) admit entry to every qualified applicant.

There are many reasons why a Canadian might go outside of Canada for medical school, including: lack of requirement for a full undergraduate degree prior to starting (thus sometimes allowing admission from high school); personal or familial ties to other countries; more affordable tuition; differing admission requirements; an opportunity for adventure; interest in permanent emigration, etc.

Assessment by the Medical Council of Canada

IMGs, including CSAs, require more steps before being eligible for the LMCC designation.[56]

The MCCQE tends to be a bigger challenge for physicians trained outside of Canada, with lower first-attempt pass rate for all IMGs.[57] Having attended a medical school not focused on this Canadian test, there may be gaps or different focus of the curriculum. If they want to attend a prep course, CSAs will have to pay out-of-pocket and complete on their own time, rather than having MCCQE prep an integrated part of their final year curriculum. They also will not have the advantage of local students and faculty members with inside "tips" for success.

They also need to pass the National Assessment Collaboration (NAC) exam,[58] which is a structured clinical skills exam offered twice yearly, at additional cost. Unlike CMGs, who can apply to CaRMS at the beginning of their final year of medical school before any MCC-administered exams, IMGs must pass both the MCCQE and NAC prior to application to CaRMS.[59] They may also require language proficiency testing and a lengthy medical credentials verification process.[60]

(The requirement for CMGs to pass a national standardized clinical skills exam apparently never mattered very much anyway, as the previous MCCQE part 2 exam, focused on similar issues, was cancelled for logistical reasons during the pandemic and never reinstated. [61])

CSAs who seek licensure in Canada further out from medical school, for example, after residency training or practice in another country, are likely to find the MCCQE and NAC even more challenging given the broad medical knowledge tested by each.

Matching to a Post-Graduate Residency Training Program

Obtaining a residency training position in Canada is a key step for most CSAs—after completion of a CFPC- or RCPSC-accredited residency, their future employability and eligibility in Canada is all but assured. However, many CSAs are unaware of just how difficult this hurdle this can be.[62]

IMGs including CSAs are explicitly excluded from most positions offered in the "first iteration" of the main CaRMS residency match. For the current (2025) match, 2076 positions are only open to graduates of Canadian medical schools, comprising the vast majority of residency positions in Royal College-accredited specialty training programs and most family medicine positions.[63]

It is illegal in Canada to discriminate for employment purposes on the basis of "place of origin". However, training institutions and CaRMS apparently assert that "place of training" is not the same as "place of origin" which could be illegal to ask. For that reason, they should not be subject to the same restrictions on their hiring as might otherwise apply. At least one provincial Human Rights Tribunal has agreed that the place of training should not be considered the same as place of origin for this purpose,[64] but another jurisdiction found essentially the opposite.[65] Still, reserving of CaRMS spots for CMGs is an example of the obstacle regulators and others raise to deny access. From an educational point of view, it is hard to see why this matters.

It is also worth noting that human rights protections were created to improve access to opportunities, services and benefits that were otherwise denied. Yet our medical leadership, instead, feels it has the duty and the right for the opposite effect, to deny such access for rationales that deny any benefit to anyone, whether the applicants or their desired training programs. In other words, they only deny access because they can.

Currently, IMGs who are permanent residents or citizens, including CSAs, can apply freely to "leftover" residency spots after the first algorithmic match of CMG applicants. These spots tend to be very restricted in terms of the specialties and programs available. This selection of leftovers is based on political decisions as much as anything else; it is ultimately the government of the province that determines the number and types of residencies they will fund.[66] Whether this "two-tier" application and selection system is allowed under the *Canadian Charter of Rights and Freedoms* is a matter that remains before the courts.[67]

The AFMC, while denying "statutory or legal authority" over the two-tier system, admits that is has always strongly advocated for a match that favours CMGs.[68] They believe they have an obligation to ensure that no training they have provided (at great expense to their respective provinces) is wasted. Obviously, this is a nice thing for CMGs, and is said to be in the public interest, but it is unclear whether it truly results in an optimal distribution of post-graduate training positions to candidates who will have the greatest benefit to Canadian patients. It is clear why Canadian medical schools (who also administer residency programs) have this protectionist attitude; any graduating medical student who fails to match to a residency program is seen as a failure of that school to produce a competitive and successful applicant.

Within the current system, programs are flooded with hundreds of applications for each spot offered in the second iteration of the match. Ironically, selection committees will likely have more useful information available to them from these applications, including scores on the MCCQE and NAC (as well as other

international standardized tests). Still, more data would be available about all applicants in the second iteration.

It can be acknowledged that there has been incremental progress has been made in the availability of CaRMS match spots to non-CMGs over the years. In 2024, 2274 IMGs applied to the CaRMS match for a first-year residency training spot, of which 671 (30%) received an offer.[69] This is an increase over 555 spots the prior year. Nevertheless, competition among IMGs for limited residency spots remains much more competitive than between CMGs, who have a match success rate of over 95%. These CSA applicants often are of limited resources confronting our medical hegemony.

Return of Service Agreements

In many cases, an IMG may only access a position by signing sign a "return of service" contract. In essence, in exchange for a residency spot funded by a province, the physician agrees to work for a certain number of years after graduation in that province, usually in a rural, remote, or underserved community. CMGs, who have greater freedom of choice in residency positions, will sometimes commit to work in an underserviced area in exchange for monetary bonuses or debt forgiveness, but these are voluntary arrangements, for purposes of securing a particular post. For many IMGs desperate to start medical careers in Canada, these agreements are not voluntary and can be enforced with hefty penalty clauses,[70] as much as $800,000.

Obtaining licensure after international residency training

One option for CSAs who have graduated from foreign medical schools is to pursue residency training elsewhere and then apply for employment and licensure back home in Canada on the basis of those credentials. This is a reasonable option although it comes with its own series of hoops to jump through. Canadians on study visas in other countries may be barred from post-graduate training in those places due to lack of pathways for work authorizations/visas required for employment as a resident or house officer.

Then there are the difficulties in having international post-graduate training recognized as equivalent to Canadian residencies in many provinces. Different provincial licensing colleges can have very different standards. In recent years, some provinces have adopted the obvious policy of recognizing some countries' training standards as fully equivalent to the RCPSC or CFPC requirements. For example, in some provinces specialists with America, UK, Australian, or New Zealand licenses are eligible for unrestricted licenses without

applying the Royal College for eligibility.[71] Other provinces remain much more strict, for example in British Columbia it remains almost impossible for some specialists to obtain a full license, even after passing the relevant Royal College exam, if they did not pursue primary specialty training in Canada.[72]

These obstacles prove insurmountable for many. It is estimated that less than half of internationally trained doctors living in Canada ever actually practice medicine here.[73] [74] [75] This seems like an unnecessary waste of potential.[76]

IV. Other challenges faced by IMGs

IMGs, whether Canadian-born or not, face other challenges if their "place of origin" or "place of training" was outside the "White Commonwealth." Canadian training programs and licensing authorities have always valued some countries' credentials more than others. There are many practicing physicians in Canada hailing from the United Kingdom, Ireland, Australia, New Zealand, and South Africa. Doctors coming from "other" countries have historically faced more hurdles.

These possibly xenophobic attitudes go back decades and are not unique to medicine.[77] This is supposedly based on a hierarchy of talent and quality of training. It may well be that applicants from some countries will have more trouble training or adapting in the Canadian system, but we should not jump to generalizations without some valid assessment of the individual candidate.[78] Nor, as far as we can see, has there ever been a direct, objective ranking among all these schools to prove that some graduates are inherently better suited to Canadian practice than others. In the past, some provinces explicitly ranked some countries' medical schools as better and were found to have been discriminatory in doing do.[79]

Return of service agreements, discussed above in the context of CSAs, make even less sense as applied to the recruitment of physicians both born and trained outside of Canada. Evidence suggests that the CMGs most likely to practice in rural areas and underserved provinces have existing family or personal ties to those areas. Medical schools across Canada have attempted to enhance rural recruitment through various types of community-based longitudinal integrated clerkships[80] and rural rotations. However, forcing rural return of service contracts on IMGs is a questionable policy. It is clear that when an individual is "billeted" in a particular place, not of their choosing, there is every likelihood that they will try to leave early, either by simply absconding, by paying off the debt, or just by waiting until they are unshackled. In other words, it creates unhappy physicians. It is not uncommon, for example, for physicians to be practicing in one province while their families are working and living in another. This is not what rural healthcare needs. The

exploitation of physicians eager to access any available pathway into legitimate Canadian licensure should not be a cornerstone of health human resources planning.[81] [82]

V. Canadians studying medicine abroad: a resource that must not be wasted

Canadian students who are taking their medical training outside of Canada may number as many as 3500, suggesting that about eight hundred graduated doctors could be added to the Canadian system every year. These students do not have immigration or study/work visas issues as barriers to recruitment. They are almost all native English or French speakers with strong ties to Canada, many to underserved and rural communities. There is every reason to believe that they are appropriately qualified based on their undergraduate training, but they run into several bureaucratic restrictions when attempting to access postgraduate training in Canada.

The bottleneck of residency training positions is controlled by provincial governments. Although funding a postgraduate residency spot costs money, it costs less than the sum required for undergraduate and post-graduate medical training combined. In addition, although residents are paid a salary and therefore "cost money," they provide essential and cost-effective labour for provincial health systems. Provincial governments could fund new residency spots and open applications to welcome CSAs with ties to the region; this could have a return on investment in as little as two years for family medicine residents who are enticed to settle in that province to practice.

VI. Conclusion

Canada's physician workforce has always relied on internationally trained physicians. CSAs in general are eager to be recruited and recognized as equivalent to their Canadian medical school peers. Unnecessary regulatory, bureaucratic, legal, and policy barriers should be removed as quickly as possible lest these talented Canadians decide to practice elsewhere, possibly for good.

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