UNIVERSITY OF WATERLOO

WOMEN WORK & ECONOMY

POLICY BRIEF

Underemployed Internationally Trained Women Physicians: An Opportunity to Address Canada's Healthcare Worker Shortage

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Executive Summary:

Canada is experiencing a significant shortage of healthcare professionals. Despite Canada's prioritization of attracting foreign born healthcare workers, there remains barriers to employment in the field of training for internationally trained doctors resulting in mismatched skilled labour and an untapped population who could support the nations desperately needed healthcare workforce. Re-accreditation programs and Return to Service policies negatively impact doctors' ability to integrate into the Canadian medical system and may disproportionately affect female physicians. Recent findings from the IRCC found medically trained immigrant women were the most likely group to be underemployed and felt that their skills did not match their current employment. This policy brief discusses the implications of the healthcare workforce shortage and barriers to entry for internationally trained doctors through the re-accreditation process. Specifically, immigrant women trained as physicians are an under-represented population of highly trained individuals who are deserving of additional support integrating into their trained professions. Policy recommendations include removing requirements for remote/rural service requirements with steep financial penalties, improving pathways for residency placement for immigrant women, and creating alternative training programs for integration into other professions in the medical field with similar skillsets.

Women, Work and the Economy Research Group

Problem Statement:

Canada is currently experiencing a healthcare workforce shortage across all provinces and territories, all healthcare sectors, and across all disciplines. Currently, an estimated 6.5 million people in Canada do not have a family doctor or nurse practitioner, which has increased by 2 million since 2019 (Duong & Vogel, 2023). Shortages of family doctors put a strain on the healthcare system, both economically and in quality. Patients who do not have a family physician often resort to emergency departments for care, which are more costly and creates additional strain on hospitals, reduces their capacity and leads to longer wait times (Li et al., 2023). Additionally, a nursing shortage impacts the ability of hospitals and other healthcare infrastructures to provide care. Projections before the pandemic had estimated a shortage of over 117 thousand nurses by 2030 in Canada (Murphy et al., 2023). However, this projection was far surpassed by 2021, when job openings for nurses across Canada reached more than 180,000 vacant positions (Baumann & Crea-Arsenio, 2023).

Canada's approach to address this shortage has been to seek healthcare providers from other countries, a controversial practice said to negatively impact the countries these healthcare professionals are from (Government of Canada, 2023; Walton-Roberts & Bourgeault, 2023). Despite prioritizing training and employment for healthcare providers who have immigrated to Canada, there remain gaps in who receives access to resources to practice in Canada and significant barriers for those with the most training.

Internationally trained regulated healthcare providers experience additional barriers to becoming employed in the profession they were trained in. Both nurses and doctors must be permanent residents to not only work in their fields, but to undergo the re-certification process necessary to practice. Additionally, recently immigrated healthcare providers must navigate a healthcare system and labour market they are unfamiliar with, they may lack language fluency required for employment, and they may lack professional networks and Canadian job experience which aid in the job search (Boyd & Schellenberg, 2007). Underemployment for medical professionals in Canada is also a result of licensing and re-accreditation barriers, especially for internationally trained doctors.

Becoming employed as a nurse in Canada requires passing nursing exams and registration with the college of nurses (Government of Canada, 2024). To become registered, internationally trained nurses with a recognized international education are only required to pass exams and are not required to have additional training in Canada if their nursing credentials are approved (Government of Canada, 2024; CNO, 2020). Organizational supports are regularly available and designed to help them through these nursing exams, such as those offered by Care Centre for Internationally Trained Nurses (CARE, 2024). In contrast, medical doctors trained in other countries have the largest barriers to practice their profession of all healthcare workers. To

practice medicine in Canada, internationally trained doctors are required to undergo a re-training process that is expensive and time consuming.

To qualify for the re-accreditation process their medical training must be from a recognized medical school listed with the International Medical Education Directory and they must pass the Medical Council of Canada's Evaluating Examination (MCCEE) (Boyd & Schellenberg, 2007). In addition to passing the MCCEE, most provinces require foreign trained doctors to have at least two years of additional post-graduate medical training, otherwise known as residency programs, from a Canadian University to practice family medicine, and four to five years training for other specialties. Further examinations may be required by the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada (Boyd & Schellenberg, 2007; Royal College, 2024; CMQ, 2024; MCC, 2024a).

The Medical Council of Canada currently supports the Practice-Ready Assessment program which is an accelerated route to licensure to practice for international physicians (MCC, 2024b). This program is available in nine provinces and offers a clinical workplace assessment over 12 weeks where internationally trained general and family doctors practice under the supervision of a physician assessor. However, this program is highly competitive with limited spaces and only for general/family practitioners. In Ontario, this program only accepts 50 physicians per year and to qualify for this accelerated program, physicians typically are required to have:

- evidence of a minimum of 2 years of post-graduate training in family medicine (i.e. a residency program),
- demonstrated completion of the seven core rotations,
- evidence of having completed three consecutive years of independent clinical practice,
- evidence of clinical practice over 960 hours within the past three years.

Following acceptance to this program and its completion, the physician is further required to agree to a Return of Service agreement in which they are contractually required to work in a designated rural community for three or more years or face steep financial penalties as high as a $1 million for choosing to practice elsewhere (Mercer, 2023). If these contracts are broken, governments require the cost of residency to be paid back in full with interest. Studies reporting the impact and implications of ROS programs indicate that these contractual requirements are unwelcome, and physicians felt they had no other choice (Mathews et al., 2022). Coercive policy practices, such as Return to Service, can harm prospective medical professionals, and deter them from attempting the reaccreditation process.

For those who are ineligible to apply for accelerated programs, there are other pathways to licensure that require extensive time and financial commitments. One pathway is through

applying for the Canadian Resident Match Service (CaRMS) R-1 Main Residency Matching system. This requires being matched and completing a full Canadian residency program (MCC, 2024). Applicants may also apply to specific international residency programs that have different requirements depending on the medical school attended and whether it has been accredited by the Royal College of Physicians and Surgeons of Canada for equivalency of training standards (Royal College, 2024). Applying for residency is not a guarantee for internationally trained doctors due to the highly competitive matching process and limited residency spots for non-Canadian trainees.

This disadvantage faced by foreign-born doctors is amplified for those who are female in the profession. Results from Canada's Racialized Immigrant Women and the Labour Market project found women with medical training who immigrated to Canada are the mostly likely group of professionals to be underemployed and feel that their skills did not match their employment, in which they were overqualified for the roles they were employed in (Ferrer & Dhatt, 2024). They were also more likely to report lower attainment of permanent contracts and had a more intense search for employment requiring them to network or find formal agencies.

Female internationally educated doctors may be more negatively impacted by re-accreditation requirements and face a "double disadvantage" resulting in underemployment (Dolishny, 2012). Part of this discrepancy is related to patriarchal household structures, unequal division of domestic labour, and glass ceiling effects (Light, 2007; Raghuram, 2004; Schrover et al., 2007; Boyd, 1984; Boyd & Kaida, 2005). Women may delay their own re-accreditation process in support of their husbands, especially when they have children and familial responsibilities (Dolishny, 2012). Additionally, being employed contractually in a remote community for years can displace families when spouses are unable to find jobs in their profession in these communities.

Policy Alternatives

Removing barriers to practice for medical doctors would support Canada's need for healthcare workers. These may include 1) relinquishing Return to Service requirements for foreign trained physicians; 2) open additional residency positions for foreign trained doctors, 3) develop alternative training programs for foreign trained doctors who have already done residency elsewhere. Additionally, attention to the needs of internationally trained female physicians would support greater integration into the healthcare sector in the positions that they trained in.

1. **Relinquish Return to Service requirements for foreign trained physicians**

Return to Service requirements are a coercive contractual practice that negatively affect the physicians. Removing this requirement may allow physicians to continue to pursue specialties only offered in metropolitan areas as well as allow families to remain together, especially if

both spouses are medical professionals. However, removal of this requirement may negatively impact rural communities where medical professionals are needed. Alternatively, the Canadian governments can provide incentives for Return to Service remote/rural work, rather than coercive and punitive measures. These may include additional financial supports, debt relief, or other incentives that can draw professionals to work in these communities. Financial incentives may not have the political acceptability necessary for policy action, as the funds necessary may be economically infeasible to attract the necessary doctors for rural and remote locations. This action may also lack effectiveness in supporting the immediacy of need for more healthcare workers in the Canadian healthcare system which affects metropolitan areas in addition to rural and remote locations. However, attention to the impact of Return to Service requirements specifically on women is necessary for gender responsiveness. Currently, the impact of this requirement has not been studied for women, especially women with familial responsibilities. To support women's re-integration into the medical profession as internationally trained physicians, specific barriers need to be researched to offer appropriate policy action.

2. Open additional residency positions for foreign trained doctors

Canada has one of the most competitive processes for medical school applications and matching in a residency program (Jubbal, 2022). Provincial governments determine the available residency positions and in which specialties (Wilson & Bordman, 2017). Through creating more opportunities for residency placement for foreign trained doctors, re-certified professionals can enter the workforce more quickly. More opportunities can reduce the uncertainty of placement and encourage those with the credentials to pursue recertification. Critique of enabling internationally trained physicians to match in residency programs have been made suggesting that it creates additional pressure on Canadian graduates. However, opening more spots can introduce a less competitive environment for residency matching whether trained in Canada or internationally. The cost of opening more residency spots may be a deterrent for provincial governments because they are responsible for funding this training (Wilson & Bordman, 2017). However, the investment into training medical students is also a function of public funding which suggests that it is wise to continue to support medical students into finishing their training with residency programs (Wilson & Bordman, 2017). Additionally, the need for trained doctors is a pressing concern across the Canadian healthcare system which can only be rectified by fulfilling mandates for residency training whether an applicant is a Canadian trained or internationally trained doctor under current policy constraints. To address the underemployment of medically trained immigrant women, certain residency spots may be reserved for immigrant women.

3. Develop alternative training programs for foreign trained doctors

During the COVID 19 pandemic, British Columbia developed a program where foreign trained doctors could work as Associate Physicians under restricted licensure with direction and

supervision from attending physicians (CPSBC, 2024). Similar to the Practice-Ready Assessment program, the Associate Physician program filled immediate needs during crisis and could open pathways for physicians who have already gone through residency programs and cannot apply to the Practice-Ready Assessment program. Concerns over training standards and ensuring ethical and safe practices merit consideration if implementing such a program. Oversight necessary may strain the practices of fully certified and practicing physicians, however, could supplement the current shortage of doctors and address burnout for those currently working. Alternatively, programs that enable physicians to re-train as nurses may enable more immigrant women work in the medical field, albeit in a different capacity. These may include accelerated programs specifically for internationally trained physicians to work as nurse practitioners or registered nurses. Currently, internationally trained doctors are not qualified to take nursing exams or work as nurses (CNO, 2020), changes to this policy may be a viable route for employment with similar skillsets.

Addressing the shortage of physicians and other healthcare workers in Canada requires dismantling system level barriers preventing internationally trained doctors from employment within their trained disciplines. This policy brief recommends a combination of approaches that address the gendered discrepancies that prevent immigrant women from reintegrating into the medical field. These include revising Return to Service requirements with consideration of impacts to families, opening more residency spots with some reserved specifically for immigrant women, and offer the option for physicians to retrain as nurses. A combination of approaches is necessary to address the multiple reasons for the lack of reintegration of women physicians into the medical field. While addressing the re-licensure process is necessary for all internationally trained physicians, specific attention to gendered dynamics that may further impede women's ability to retrain, or policies that create additional barriers for women who have familial responsibilities need to be considered.

Recommendations

Implementation of these recommendations will require coordination with provincial governments, medical schools, and appropriate regulatory colleges.

First, policy recommendations should be supported with evidence. However, there is a lack of research that explores the experiences of immigrant women physicians in Canada. Specifically, there is a need to understand the specific impacts of the Return to Service requirements and how they affect immigrant women. Funding bodies, such as the Immigration, Refugees and Citizenship Canada (IRCC), can support further research on the barriers to practice for immigrant women physicians to support evidence-informed policy action.

Second, the development of transition pathways for internationally trained physicians to re-train as nurses may be an option for internationally trained women physicians to use their skillsets if they do not want to under-go the arduous process of re-training as a physician. Coordination of such a program would require the appropriate regulatory association for both

nurses and physicians to agree to terms of licensure pathways, appropriate credential checking, and new training modalities that address the gaps between nurse and physician scope of practice. Prior to this program being implemented, a survey of immigrant women physicians should indicate if this is a wanted program.

Finally, provincial governments can address the limited residency spots available to both Canadian and internationally trained physicians to address the healthcare worker shortage. Provincial governments can facilitate agreements with medical schools and training providers for additional residency spots, which will include additional funding for residency training, but will fill the shortages. Consequently, the funding required would be off-set by designated funds reserved for physicians that are needed.

Currently, both those trained within Canada and internationally are required to complete a residency program, regardless if those trained internationally have already completed such training elsewhere. This is required as a measure of medical training standards and competency and to ensure the workforce maintains safety and ethical standards of the profession. While increasing the workforce rapidly is needed, maintaining this competency is among the most important factors for ensuring the safety of patients. Opening further residency spots, not only provides additional highly trained and vetted physicians into the workforce, it also ensures investments made by the governments in the medical student training programs are successfully completed.

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