HANSARD

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COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, June 8, 2011

LEGISLATIVE CHAMBER

Recruiting of International Medical Graduates

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Public Accounts Committee

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Hon. Keith Colwell
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[Mr. Sidney Prest replaced Ms. Michele Raymond]

In Attendance:

Mrs. Darlene Henry
Legislative Committee Clerk

Ms. Evangeline Colman-Sadd
Assistant Auditor General

Mr. Gordon Hebb
Chief Legislative Counsel

WITNESSES

Department of Health and Wellness

Mr. Kevin McNamara, Deputy Minister
Ms. Linda Penny, Chief Financial Officer
Ms. Lynda Campbell, Manager of Physician Resources

Immigrant Settlement and Integration Services

Ms. Jan Sheppard Kutcher, Manager, Employment Services
Ms. Sepideh Behroozan, Coordinator, IMG Bridging Program

College of Physicians & Surgeons of Nova Scotia

Dr. Cameron Little, Registrar and Chief Executive Officer

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, JUNE 8, 2011

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Ms. Diana Whalen

VICE-CHAIRMAN
Mr. Howard Epstein

MADAM CHAIRMAN: I will call the meeting to order. This is the meeting of the Public Accounts Committee. This morning we'll be looking at the recruitment of international medical graduates as the subject for our discussion, and we are joined by witnesses from the Department of Health and Wellness, the Immigrant Settlement & Integration Services organization, and also the College of Physicians and Surgeons of Nova Scotia.

That means we are going to have several short opening statements and some information for the committee before we get going with our questions. Before we do that, I'd like to have the members of the committee introduce themselves. If I could begin with Mr. Prest?

[The committee members introduced themselves.]

MADAM CHAIRMAN: On the introductions for the witnesses I'm going to perhaps ask that, as you do your opening statements, you will introduce who you've brought with you as well. That would be helpful to us. I'll begin with our Deputy Minister of Health, Mr. McNamara.

MR. KEVIN MCNAMARA: Good morning. I'd like to start, as mentioned, by introducing Lynda Campbell on my left here, who is the manager of our Physician Resources, Partnership and Physicians Services at our department, as well as Linda Penny, who is our department's chief financial officer. Also with us today is Dr. Cameron Little, who is registrar and CEO of the College of Physicians and Surgeons of Nova Scotia. Dr. Little will not be making any opening remarks but will be participating in the answers to questions.

I am pleased to be here this morning to speak to you about international medical graduates and our work to bring more doctors to Nova Scotia, especially to the rural parts of our province. This province has 231 physicians per 100,000 population - the highest overall rate of physicians in Canada on a percentage basis. The number of doctors practicing in Nova Scotia is growing. Last year alone we added 20 new doctors. District health authorities across the province recruited 96 doctors, and 76 left the province to practice elsewhere, or retired, passed away, or became inactive as doctors for other reasons. But an overall number misses some important details, and we see the need for strong primary care, including family doctors or general practitioners, in our rural areas.

International medical graduates help us provide medical services in those areas, and they've been a pretty good option for Nova Scotians and an option where we expect to see even greater success in retention. In fact, about 30 per cent of doctors in Nova Scotia are international medical graduates, which is above the Canadian average. We're working on a project to estimate the physician resources we will need for the next ten years. This project will tell us how many and the mix of doctors we need and where they are needed. Today we're here to talk about international medical graduates and to answer your questions.

Nova Scotians have told the department how frustrating it is to be without a family doctor and to not get the health care they need when they need it. We see some communities, mostly rural ones, facing difficulties in recruiting doctors. The Department of Health and Wellness works with district health authorities to recruit and retain doctors and we prioritize communities with chronic problems. Nova Scotia has several programs that support doctors into moving in a practice.

We use the recruitment programs to help attract doctors to underserviced parts of our provinces, they are listed in the information we provided to the committee and I will mention a couple of them. The Clinician Assessment for Practice Program is a College of Physicians and Surgeons of Nova Scotia program for international medical graduates that are practice ready without further training, the department funds the college to provide this program.

The Return of Service Program is Department of Health and Wellness funding for eight new international medical graduate residents each year. Once they complete their studies they have a commitment for return of service, this program started in 2007. Debt assistance is available to any doctor who wants to practice in rural Nova Scotia, repayment

is over three years and the doctors agree to maintain a full-time practice. Funding mechanisms under the master agreement also encourage doctors to practice in rural communities. As well, for doctors who are considering a practice in priority areas outside of Halifax we help them investigate the opportunity by funding site visits and help with their relocation expenses.

Many of those who take advantage of these programs are international medical graduates. Many factors bring doctors to Nova Scotia, some are looking for a new country to call home. Most want to live in communities that can provide services for their families like schools and activities for their children and where their spouse can also find work. Nova Scotia doctors provide medical service largely to residents of this province, however, many specialists provide care to people living across our Atlantic Region. Nova Scotia also has a group of doctors who, in addition to providing patient care, conduct research, train other doctors or other health care professionals and fulfill leadership roles within health care. This is a fairly complex structure providing medical service and we're working out to determine what will be the right number of mix of doctors for the province for the coming decade.

At the end of our physician resource project we will have considered changes in demographics, changes in the health of Nova Scotians, changes in the way medicine is practised and the way health care is delivered. In the Fall we expect to have a clear picture of our revision resource need and we will work with our partners, Doctors Nova Scotia, and the medical school, the district health authorities and the College of Physicians and Surgeons of Nova Scotia, who are here with us today, to turn the projections into a health care service.

Changing roles among health care professionals and advances in information and other technologies are expanding the ways the health system can meet patients' needs while remaining affordable into the future. As the system goes through these changing times we move carefully. Doctors make decisions every day that can affect people's health and their lives. We need to be sure any doctor practicing in Nova Scotia has the full training and expertise needed to provide the types and level of service that Nova Scotians need and expect. That is the role of the College of Physicians and Surgeons of Nova Scotia and we do support them in that work.

Thank you for this opportunity and we look forward to answering your questions.

MADAM CHAIRMAN: Thank you very much, Mr. McNamara and I think perhaps Ms. Sheppard Kutcher you have a few opening statements. I know you've given us a package, I appreciate that. If you have a short statement we'd like to give you the chance to do that and you can introduce your staff person with you.

MS. JAN SHEPPARD KUTCHER: My colleague is Dr. Sepideh Behroozan who is the coordinator of the IMG Bridging Program ISIS where we both work. I've worked in

this field since 1997, ISIS is the largest immigrant serving agency in Atlantic Canada. We see 3,500-plus immigrant clients every year both in HRM and across the province. In the past year alone my team has assisted 178 IMGs, including 111 family physicians and 67 specialists.

I'd like to make just a few comments under three general themes: one, this is a good news/bad news story; secondly, it's a complex challenge that requires complex solutions; and thirdly, Nova Scotia has the potential to be the best in this area. Bad news/good news, when I first started working with IMGs in the late 1990s, there was a literal brick wall: no routes to licensure, Catch-22 barriers - financial barriers - it was a very bleak situation. Fast-forward to today, although I can think of IMGs such Ahmed who is still driving a cab, I can also think of IMGs such as Dleer who gave up cab driving and is now working as a clinical associate at the QEII. Although I can think of Parviz who left the province in utter frustration, I can also think of Ryve and Fouzia who are practicing as family physicians in underserviced parts of the province; Amna, Najat, Rosario who are in residency programs; and Heizer, a fully qualified psychiatrist - all of them IMGs.

There are significant hurdles. Access to training opportunities is still extremely limited. The time and money needed for examinations makes it very difficult, particularly for specialists, the unfamiliar formats of clinical evaluations, challenges of learning the language and the culture of the health care system, and the ticking clock because five years out of practice is considered to be a major problem in terms of re-entry. But today we have an IMG Bridging Program at ISIS, which my colleague coordinates and which provides a variety of supports and services to assist IMGs. We have made much progress but there is yet much to be done.

Complex challenges need complex solutions. We provide individual assistance to IMGs, but it didn't take a very long time working in this field before we realized that individual assistance would not be sufficient. I began my search for answers many years ago and quickly learned that this issue of IMG accreditation is not one that's owned by one organization or one stakeholder. It's commonly thought that the regulatory authority, the College of Physicians and Surgeons, is really the problem. The college is only part of the problem/part of the solution. To identify and eliminate the barriers, to develop pathways to licensure, to avoid duplication, to create opportunities for collaboration, it's fundamental to bring all the players to the table on a regular basis.

So over the past few years there has been significant time and effort dedicated to the development of a multi-stakeholder work group, an IMG multi-stakeholder work group. It's a collaborative model for addressing these challenges. It's led currently and very effectively by Dr. Cathy Cervin who's with the Dalhousie Faculty of Medicine, it meets quarterly. It includes all the key stakeholders, including my colleagues at the table here; the college, Dalhousie; Department of Health and Wellness; the Association of International Physicians and Surgeons; Capital Health; Doctors Nova Scotia; ISIS; and so on. It has resulted in substantive changes and collaborative programs because it provides a forum for

debate, for discussion, for vetting new ideas, and for moving forward. All the players are at that table on a regular basis.

This is a complex problem, there's no doubt. Frequently I hear in the media that if only credentials could be recognized, everything would be fine, but in the field of medicine recognition of credentials - and that's done by the Physician Credentials Registry of Canada - is only the very first step. It's what route to follow, what's possible, feasible, and it depends on so many factors, including whether it's a family doctor or a specialist, the amount of clinical training and clinical experience, where it's from, how long someone is out of practice, what their family situation is, et cetera. More complexity results from the fact that, provincially, the College of Physicians and Surgeons controls physician registration and licensure, but for specialists, the Royal College of Physicians and Surgeons of Canada is the national professional association that oversees the medical education of specialists across the country.

Nova Scotia has the potential to be the best. Nova Scotia now has a number of different pathways to licensure, and that is a strength. In other provinces there is often one IMG route. IMGs are an extremely diverse group, and a variety of options makes far more sense than one pathway, so with the stakeholder group: number of routes to licensure; the practice-ready route for family physicians with the CAPP; the beginning of a specialist route to licensure; the immigrant IMG Clerkship program, which is unique in Canada; residency programs that are designated for IMGs; the Bridging Program; and the availability of clinical associate positions all set Nova Scotia up to move forward. The foundation has been laid, but we are not there yet. I will present some suggestions for moving forward in my concluding remarks.

[Mr. Howard Epstein took the Chair.]

MR. CHAIRMAN: Thank you very much, Ms. Kutcher. As everyone can see, Ms. Whalen has stepped down for the moment because she'll be asking some questions.

Our procedure is to go in two rounds. There will be an initial round of 20 minutes for each caucus to ask questions, and then there'll be a second round, and depending on how many minutes we have left, it will be divided equally amongst the three caucuses.

I should note that since we began we've been joined by Mr. Allan MacMaster, MLA for Inverness. We will now start our first round of questioning with Ms. Whalen.

MS. DIANA WHALEN: Welcome to everybody. I'm really pleased that we have a chance to talk about this issue today here at the Public Accounts Committee, and hopefully we'll get more answers and see a way forward.

First of all, I'm really glad to hear there has been such progress. I know in the time I was first elected, in 2003, there wasn't much activity. I do see a big difference, and I'm

really pleased to see that. I think a lot of us may speak about what we hear as MLAs and people who visit us in our offices. While I recognize that often it will be people who are having difficulties who come in - those who have made their way through the system may not visit us - we do hear the stories of people who are frustrated, who feel that the avenues to licensure are difficult or may be insurmountable. You know my perspective, as an MLA, is that I want to respond to that.

I also hear the issues of shortages of doctors, particularly in rural areas or underserviced specialties, so we feel like there's a little bit of a mismatch still going on and we want to do what we can to improve that. I think there's a human element here, too; while we're talking about numbers and the process, I don't think we should ever forget there's a human element of people who have come to Canada with high expectations. We've actually encouraged them because of their education, and they come here and are often very disappointed or meet with obstacles that were unexpected. We need to make sure that people understand the process before they come, and that we have avenues to help them.

I know it's going to be a little difficult about who the questions are for, so I will try to mention exactly who I think should answer them as I go. I'd like to start with a little more understanding of the CAPP numbers and how that has been working, so I'd like to begin with Dr. Little, if I could.

I had figures from the year it began, Dr. Little. It started in 2005 with 60 participants in the first session, 12 of whom were living in Nova Scotia. I'm wondering if you could tell me, in the most recent application process, how many applicants were from Nova Scotia and how many you had in total?

DR. CAMERON LITTLE: I can't give you the exact figures, but we've had over 200 physicians as applicants for the CAPP, and roughly 20 per cent have been successful in being licensed and practicing in the province, so it's around 52, I think. Actually, Lynda Campbell could probably give you the more recent numbers.

The applicants must be permanent residents or citizens of Canada. We don't actively take physicians who are overseas. We're trying to look at the sort of human intellectual capital in the country, because the vast majority of immigrants and IMGs are in the Greater Toronto Area and some of the cities out West and in Montreal. Most of our applicants come from the Greater Toronto Area.

We have certain criteria and we feel that we'll take any IMG that fulfills their admission criteria into the count. The CAPP is going on this week. The next run, I think we have 32 candidates going through at this time.

MS. WHALEN: Okay. Initially, you had two times a year that you were doing the assessments for CAPP, has that continued or is it reduced?

DR. LITTLE: We just do it once a year. We dodged a snowstorm that first year and we would have probably had no candidate. Because they're coming from Toronto, there was a big snowstorm here just about two days before and they just got the runways cleared to get them all into the province. We decided at that time, in looking at numbers, the most efficient way of doing this is to have at least 20 candidates at any run.

If you have fewer than 20 it's not very cost effective. If you have more than 30, it's not cost effective. The way it works out is 30, 60 et cetera. We decided, because the numbers of applicants dropped in subsequent years, we would just do it once a year, probably in June because of the weather. It also it gave us the ability of those candidates who weren't successful to apply to the CaRMS match in the coming February and it only gave them six months they would have to wait around to do that.

MS. WHALEN: So the timing worked out best that way.

DR. LITTLE: The timing worked out best that way.

MS. WHALEN: I only have 20 minutes, as the chairman knows, in my round so I may interrupt. I don't mean to but I'm just looking for quicker answers.

I had looked in my research for this in some of the other provinces, Manitoba's site in particular has a lot of the stats on the site. It actually tells you how many applied, how many were resident of the province and how many were successful and how many were the second tries as well. It tells you whether they were coming back a second time. I wondered if there had been any thought to doing that here in Nova Scotia, again to Dr. Little, and whether or not we could get the stats here for the last six years, I guess, since 2005, if you'd be able to provide them to the committee?

DR. LITTLE: I'm sure I can.

MS. WHALEN: That would be great so we'll keep a record of any requests of information. As I say, that would help us in knowing how well we're doing. You did mention we've had more than 200 who have applied and 20 per cent roughly who are successful. We have that as a basis.

Could you tell me if we've looked at how many stay in the province after they fulfill their two-year requirement, if they're successful and they are placed in Nova Scotia, they have a two-year requirement to work here?

DR. LITTLE: Well, they have a four-year contract, I believe, with the Department of Health and Wellness. In that period of time, they're supposed to become fully licensed and get their LMCC, their Licentiate of the Medical Council of Canada exams and do their College of Family Physician examinations and get a full licence.

Their first sort of cohort has just come through and actually Lynda Campbell could probably address that, but roughly, after two years away from the finish of their four-year contract, only one of 10 is still in the province.

MS. WHALEN: Basically, once they get their full licence, after two years, you say they take their national exams?

DR. LITTLE: They get four years to do their full exams and if they do that they get a full licence.

MS. WHALEN: Then they're free to go anywhere in Canada?

DR. LITTLE: They're free to work, to go anywhere in Canada.

MS. WHALEN: Ms. Campbell, maybe you could provide a little bit more context around that, is it true that one in 10 have stayed in the province?

MS. LYNDA CAMPBELL: For the first cohort that did the exam in 2005 there were 10 and one is still practicing in the province. For the next two cohorts, we have 12 and eight are still in the province.

The first round, our retention was not very good and it has certainly increased since then. However, as Dr. Little indicated, the time frame is fairly short since they started completing so I think we'll need a little bit more time to see what the performance is over time.

I would also comment that a number of changes have been made, adjustments to the program over the life of the program. The first cohort didn't have access to an orientation program, they didn't do site visits to visit the different communities that they would be available to. Now that has changed significantly. There is a one-week orientation for all candidates who are successful, and then they do a one-week tour of the province to the communities that are available, meet with the medical communities, visit the schools, whatever . . .

MS. WHALEN: So you'd get a better match, perhaps, in terms of . . .

MS. CAMPBELL: And it gives them more of a sense of options as well, as opposed to in the first cohort they may have been given very few options.

MS. WHALEN: Can I just check the numbers now? You say in the next following two years there are 12 in each year, is that right? Or is it 12 in total?

MS. CAMPBELL: Twelve in total in the second and third cohort.

MS. WHALEN: Combined, there's 12?

MS. CAMPBELL: Yes.

MS. WHALEN: And you've got eight of them still in the province?

MS. CAMPBELL: That's right - who have finished their contract. They have completed their four-year contract. Of the 40 who have been issued contracts from the beginning, only one did not complete.

MS. WHALEN: That would be to the point of not being fully licensed?

MS. CAMPBELL: Not to the point of completing the four-year contract.

MS. WHALEN: Okay, so they fulfill the four-year commitment, by and large, but then many of them leave the province?

MS. CAMPBELL: The first cohort, many of them . . .

MS. WHALEN: Could we ask for your stats as well? I know we're going to get some from the college, but if we could get your statistics? Again, I think from the issue of transparency it would be great to have that on the Web site for anybody as well. Even people who are exploring this from overseas, they would have an idea, or looking at it from another province perhaps to come to Nova Scotia, it gives them an idea of how we're doing and how IMGs are faring, so that would be helpful, too.

I have some other questions for the college, again, relating more to the cost of the program, to actually sit and take the CAPP. I wonder if you could tell me what the cost was in the first year, when it began in 2005; I understand that the immigrants themselves, or the IMGs, pay for this program.

DR. LITTLE: I think it has been the same for each iteration. It's $5,500.

MS. WHALEN: It is $5,500? I've heard of a figure of over $6,000. Are there other fees that come into play? I was told something like $6,300.

DR. LITTLE: Not that I know of, I'm sorry.

MS. WHALEN: I thought maybe there might be a national fee or some other?

DR. LITTLE: No.

MS. WHALEN: No? So to the College of Physicians and Surgeons it's $5,500?

DR. LITTLE: Well, it's to the CAPP itself. The CAPP is run independently from the college. We run it, but it is administrated quite differently, so it actually goes to the CAPP itself.

MS. WHALEN: So you don't roll it into sort of your general revenue and then pay for the costs outside of that?

DR. LITTLE: No.

MS. WHALEN: I guess I was looking to see whether there was a profit margin in this. I wondered if you've costed it, then, so that you know exactly what the costs associated with delivering it are.

DR. LITTLE: We know exactly what the costs are. In very rough numbers, the candidates pay about one-third, the college and physicians of the province pay one-third, and the Department of Health and Wellness pays one-third. It is not exactly one-third, but that's sort of what the rough is. We've looked at it very closely and we can't do it for any less than that.

MS. WHALEN: So for each physician you're saying it would cost more than $15,000? It would be like $16,500 to put them through the CAPP assessment?

DR. LITTLE: Every iteration, we have to have new examination stations. Those are very, very expensive. They have to be run in front of a number of family physicians to make sure they are accurate. We work with the Learning Resource Centre at Dalhousie. It's a very expensive process. We have the standardized patients who have to be trained for each one of these scenarios, and then we have to train the examiners. We have something like 32 examiners who have to be trained about those particular stations.

We have a therapeutics component, and we have to change the therapeutics exam so that that's different each time. In any event, it's a very, very expensive procedure, and I don't think anyone can do it for less than that, probably.

MS. WHALEN: I wonder if you'd be willing to break down the costs for us again. I don't expect you to have it today, but would it be possible to get a breakdown of those significant costs that are involved in preparing for the exam each time?

I think that would just help, again, in transparency, because it seems like a very high amount of money for individuals. Again, I go back to the personal side, where these are people who have come to Canada and are probably not working while they prepare for exams, and then they have a very large fee that they need to come up with while they maintain their families here, so there's a lot of pressure on them.

DR. LITTLE: Well, I should just clarify, the costs to the college - we give a lot of it in kind. In other words, we pay the salaries of the individuals; they are housed at our building, so we pay the insurance and the lighting and the heating and all of those sorts of things, so it's not as if that money is going into the actual preparation of the exam, it has to be done. So when you say $15,000, it's more like about $10,000 per candidate.

MS. WHALEN: Okay, well, if you could give us a breakdown and I understand, and I think it's good for IMGs to recognize the in-kind contribution that is maintained by the physicians, as you say, to maintain a hierarchy and your whole organization. But I do think that it would help because I think it's felt that the cost is very high. I can see that and if people are sitting at a second time, we're then talking about $11,000 and so on. So I think it would be very helpful to all the members of the committee if we could have a breakdown of that just for going forward. Again, because I've looked at Manitoba, I notice that they're charging between $4,000 and $4,500. Can you explain why there would be a difference?

DR. LITTLE: I would have no idea. I mean what they do may be very different from what we do. It's difficult to know. I mean their program is run by the University of Manitoba, I believe, and so it's completely different, it's just a different system.

MS. WHALEN: So that remains a little bit unsure but it's not run by the college in Manitoba, so it's different?

DR. LITTLE: It's not run by the college, no. We're the only program that is run by the licensing body in the country. All of the others are run by the universities.

MS. WHALEN: Well, that's a thought too for us as we go forward but, you know, I appreciate that you are the licensing body and, therefore, there's a good reason for you to be involved but I wanted to ask if there has been any thought to a payment plan or a different way to accept the funds? I mean right now I gather you would have to pay up front in order to sit for these CAPP exams?

DR. LITTLE: I can't give you the exact details but I think it's $1,000 up front to reserve a spot and then they pay the rest of it just before the exam is done.

MS. WHALEN: Could I ask if that's something you would consider or ask your organization to consider a payment plan, or some sort of way to spread it out over a year?

DR. LITTLE: Well, that's difficult to collect on those things. We've had one candidate actually who came and left the province and didn't pay the hotel bill. They stiffed the inn. So it's difficult to collect money once someone has done something. Especially if they've been unsuccessful, it's difficult to collect that money.

MS. WHALEN: I wonder if the Department of Health and Wellness has considered, or I'm sure you've been asked about some ways to assist with the CAPP costs.

Perhaps the deputy minister would be able to tell us if there's a way to look at this or any suggestions?

MR. MCNAMARA: We have difficulty in finding money to fund programs for medical students in any aspect. We do provide support in many ways for individuals to the residency program but in advance of, I'm afraid there are no funds for that.

MS. WHALEN: Okay, thank you very much. I wanted to just refer to an article that was on the CBC Web site where Dr. Little is quoted. This was from July 2010 and it says, "We need to sit back probably in the next year and really say to ourselves where are we going with this program. Should it continue? Should it not continue? Should we change it in any fashion?" So it sort of leads me to believe that you're looking for a review of the program and I'm wondering if you could let me know if any review has been done? Dr. Little.

DR. LITTLE: We have done an informal review of the program. We've looked at improving some of the aspects of it. Especially for the successful candidates, improving the orientation for them, as Ms. Campbell alluded to, doing a number of other things. It's a matter of whether or not the medical profession should be paying the amount of money that it's paying for this program. We think this is a public good and we think the public should be paying more for it if at all possible, but we're going to continue with it. We think it has been a good program for the province.

We have put roughly a number of international graduates into rural Nova Scotia that would be the equivalent of a medical school class over the past five years and we think it has been a good investment. It has been a good investment of ours, a good investment by the public, and a good investment quite frankly by the candidates themselves. These people are now working, supporting their families, and contributing to society. So I think it has been, overall, successful. So at the moment we're going to carry on with this program.

MS. WHALEN: I'm glad to hear that. I'm definitely glad to hear that you see it as a public good as well because, you know, I think it is and it's helping rural communities but it's 52 roughly, out of 200 who have been successful over that six years?

DR. LITTLE: Roughly 20 per cent, yes, or just a little over 50, I believe.

MS. WHALEN: So it's starting to become significant numbers but I look at the ones who are unsuccessful and wonder if there is some way you're reviewing it to see how we can do better in the success rate. Were there any other suggestions that came, you're referring to your informal review being more about perhaps the ones, how you helped the successful candidates.

DR. LITTLE: Last year we ran a pilot project, we had five candidates who were right on the cusp, weren't successful but we thought that with some more intense

supervision they might be successful. So we did get some funding to run a pilot in Yarmouth and one of our mentors there spent three months with these five physicians at separate times. Very intensive supervision of these individuals and after three months, of the five, I think, two or three were successful and two were not successful. So even with further supervision and education of the health system here there were still two that were not felt to be safe enough to go into practice.

MS. WHALEN: You still have more than 50 per cent success rate there so is it something you'll be willing to consider as a go forward?

DR. LITTLE: We would consider anything, providing there are the resources to do it. This is incredibly resource rich, to have a physician spending their entire day with an IMG going through every single patient that comes through is just a huge cost. We'd be willing to do anything provided that we have the resources, the financial and the human resources to do this but it takes a lot.

MS. WHALEN: Thank you, and I know my time is drawing short but I'd like to ask you about whether there has been any consideration about having some kind of means to support Nova Scotians first. You mentioned people coming, a large number from, say, the Toronto area or outside of Nova Scotia. We have immigrants who have chosen Nova Scotia as their first point of entry. If they come here initially and have made a commitment to Nova Scotia is there any way that we can recognize that through the CAPP assessment?

MR. CHAIRMAN: Dr. Little I'm sorry but I have to interrupt, the time for the first round has actually gone, perhaps we'll get to that question later on. I'll move now to Mr. MacMaster on behalf of the PC caucus for the next 20 minutes.

MR. ALLAN MACMASTER: Thank you, Mr. Chairman, and good morning everyone. I know in Inverness County, if I may speak about the area I represent briefly, we have a lot of physicians who immigrated years ago and they're still with us. Some of them are getting, I guess you could say they are past the traditional retirement age but they're still with us. So we've seen first-hand how valuable people who come from other parts of the world are, in rural parts of the province. They've certainly made themselves at home and they're part of our communities now. I went to school with some of their children so it has been a very successful situation there and I congratulate you on the work you're trying to do to assist Nova Scotia with its needs for physicians and surgeons.

I do have some questions and I'll start, my first one is the whole process, I was speaking to somebody recently who is a physician in another country and they've decided that they've liked living in Nova Scotia and they've decided they would actually like to stay here. So they are a practicing physician from another country but the challenge for them and I'm sure it's a common one, and I would open the floor to comment. Somebody who comes here with those skills and credentials, if they come here - I guess before the College of Physicians and Surgeons can look at them they have to be either a permanent

resident or a citizen. So you have somebody who's highly trained, they're ready to go, they have experience in their home country, respected, they might need to have their credentials reviewed to operate here.

In the case of this person they don't have a job here, they can't get a job in their field because despite the fact they're trained for it their credentials are not yet recognized. To become a permanent resident or citizen you need a job so they are kind of caught in the middle. What would you have to say to people who are in this situation? What advice would you give them if they say, if they commit, yes I want to stay in Nova Scotia, I have experience, I've been educated, I've practiced as a physician or surgeon elsewhere. I'm willing to go through the process to have my credentials recognized but I can't go anywhere until I get a job.

[Ms. Diana Whalen resumed the Chair.]

DR. LITTLE: Well, they could try to get a work permit. There are doctors who work in this province with work permits. Then they would go through an application process and try to get a job, and then at the end of the work permit they would apply for permanent residency that way. So that's one way they might do it.

MR. MACMASTER: Sure, and just building on that, I know that most people who come to Canada have to identify a job in order to get a work permit. I know there are some restrictions on that, because you can't just take any job. It has to be shown that no Canadian - or no Nova Scotian, I guess, in this case - is able to do that job. I think the employer even has to advertise and prove that they've tried to hire a Nova Scotian first, so it's a bit of a difficult process to get a job, for somebody who has come here.

Is there any support that any of the organizations that are here today can offer to somebody who is in that boat?

MS. SHEPPARD KUTCHER: I'll speak to that. Unless a physician is coming through the academic route to take up a post at the university, it would be very difficult to enter the country under a work permit; to identify an employer when the individual wasn't licensed would be quite challenging, I think.

However, it is possible, and many physicians have entered the country under the Federal Skilled Worker program, which does not require that a job be secured prior to arrival. As most of you probably know, that route takes quite some time. However, if a physician were to apply through the Federal Skilled Worker program, they would be well advised to start to prepare carefully and methodically pre-arrival and to look carefully at the requirements. I'm not sure what the Physician Credentials Registry of Canada - I believe that they may be able to get their paper documents recognized at that point. It's possible that they could start to write some of the Medical Council of Canada exams. The

further ahead they could get before they actually arrive here, the better the place they would be after arrival.

In our organization we are able to do pre-arrival services. We run a variety of individual programs using Skype technology. We have workshops that are facilitated, on-line workshops that help individuals - not just IMGs, but all immigrants - to prepare prior to arrival to make sure that they have the appropriate documents.

What did happen in the province was that we had a number of physicians who came in through the now-defunct economic stream of the Provincial Nominee Program. That resulted in a large number of specialists, in particular, entering the province, and they encountered some pretty serious difficulties.

MR. MACMASTER: Just building on that, you kind of answered my next question, and that is, where do people get this advice? You mentioned that they can get it from your organization, but if somebody is overseas and they're looking at Canada, does anybody point them in your direction so they can get that advice?

MS. SHEPPARD KUTCHER: Well, there's a little bit of a line to walk, because our organization - and I know the Nova Scotia Office of Immigration, and I'm sure the college is the same - does receive regular inquiries from physicians and other skilled professionals around the world who are considering immigration. At that point, while we respond and try to direct them to appropriate Web sites and information, we don't have the capacity to provide intensive services for people who may or may not be immigrants.

However, if someone has a letter of nomination, has applied through the Provincial Nominee Program and is going to come to Nova Scotia, or if they are approved to come through one of the federal programs and are waiting for a health or security check, then we will start to work with them. The best practice in immigrant settlement is to begin as early as possible, in order to provide the information and in order for as much preparation as possible to happen in the first country. That could even include language training or additional training that could be taken prior to arrival or, as I said, challenging exams in some cases, in some professions.

MR. MACMASTER: It seems to me that if somebody is looking at Nova Scotia probably the first place they would look would be the Office of Immigration so it sounds like they're getting information there or they're getting pointed in your direction, that's a good thing.

My next question, should we be looking at - if we're sincere about trying to bring doctors into Canada and into Nova Scotia - should we be looking at jobs that they could get in the health care system. These people have a lot of knowledge, even if it was a practical job in the health care setting so they could come, so they could address the issues so that they come here, they have job, they can apply for permanent residency. Then they can go to

the College of Physicians and Surgeons to have their credentials assessed, and then they can become licensed. I'll let people comment on that, perhaps maybe the Department of Health and Wellness, I don't know who would be the best to comment.

DR. LITTLE: We have what we call a Credentials Review Service so any physician around the world, and we get hundreds of requests a year, can fill out a form. They can ask us to review their credentials and see whether they might be eligible for a licence or not and what they would have to do in order to become licensed. So that is one service that we do provide. We also have a policy with regard to IMG observers, these are physicians who are here now. They're not licensed, they've immigrated here, they're citizens and they want to spend some time with a doctor in their office or somewhere observing. We have a program for that and we do that for them for up to a year while they're preparing to do their exams or some of the other things they need to do. So we have those kinds of things that go on.

A licence is important because it's the stamp of approval for the public. If the public is going to see a doctor who's licensed, saying that our organization, which has been around since 1872, has given its stamp of approval that we feel that this physician is as competent to practice medicine as we believe they are. So the public puts their trust into that, until they become licensed they're really just going to have to, as I say in our system, be an observer. They can examine patients with the doctor, they can see how the Canadian system works, they can do things that a medical student could do but they can't prescribe, they can't write notes in the chart. They have to sign a seal of confidentiality or contract because they're getting confidential information about patients and yet they're not licensed physicians. There are a number of things they have to do in order to do that but there are ways for them to get a least some experience like that.

MS. SHEPPARD KUTCHER: The observership that Dr. Little is speaking about is extremely valuable and the reason is that it enables IMGs access to the health care system and there is a lot of education that can happen in that kind of situation. The reality though is, as IMGs are working their way through these various exams they have families and they need to support themselves. They come in with some resources but those are exhausted pretty quickly with the cost of examinations.

One of our challenges at ISIS is to assist IMGs with accessing alternative careers in the health care system, we want to see them not working for McDonalds or driving a cab, we try to help them even become a phlebotomist, collecting blood in the lab, doing research. The clinical associate position that I referred to earlier allows IMGs to be working in a hospital or a clinic setting. In that way, be introduced to the culture of the health care practice, interaction with Canadian health care providers and patients and can be far more valuable than sitting at home studying a textbook. We are looking at those opportunities very seriously and are constantly trying to assist IMGs with that so that they can be employed as they go through the process of becoming fully licensed.

MR. MACMASTER: I guess I'd like to bring the Department of Health and Wellness into this, because I know there are probably certain careers in the health field from time to time where there may be a shortage. I certainly respect that you have to have credentials for anything you're doing in the health care field, but I guess the original intent of my question was looking at the practical impact of somebody who's very well trained in being a physician, maybe, who might be able to do something requiring fewer skills, still within the health care system. You've kind of answered my question. I guess I just want to further clarify if, in a practical sense, does somebody contact your office and then you help plug them into a role or at least direct them to a position that they might be able to get through the Department of Health and Wellness?

My next question beyond that is, will the Department of Health and Wellness look at them?

MR. MCNAMARA: I can start. I think what we have to look at is, it depends on the career. For example, even though they may have trained as a physician in another country, it doesn't mean that they qualify for any of our colleges that would relate to nurses or pharmacists. Sometimes that takes those aside.

When you look at some of the others, there are careers, but the opportunities end up mostly being in Halifax rather than out in the rural areas, mainly because in Halifax they do have mentorships to help them more than they would in a rural community, particularly when you have to work shifts, and often if you're doing evenings and nights you're on your own. So it's how you manage that, it's very difficult in some - but I think we're always looking for opportunities if they're available.

MS. SHEPPARD KUTCHER: You're quite right. Health care is the most highly regulated sector of all the industries that clients are coming from. There are challenges there. We have looked at some options; occasionally a physician has retrained as a licensed practical nurse, gone through some brief training. We're looking at those kinds of options, but there are some opportunities that are not regulated, as I referred to earlier, in the field of research. Some have retrained and are working as policy analysts in the Department of Health and Wellness.

We're constantly looking for opportunities that will build on the skills and knowledge that IMGs are coming in with, because they understand patient care, they understand the medical system, they have a lot that they could contribute before they are fully licensed.

MR. MACMASTER: Immigration is an interesting topic, because we say we want it, but it seems we don't want too much of it. I know I think that's the way it's perceived by people. I hear it, obviously. It's amazing when you become elected how many people come to you for help who can't even vote for you because they either don't live in the country or they're not residents here. That's one of the things that I'm hearing: the frustration of

people who say, we hear all this talk about how Nova Scotia wants immigrants and we're short in certain positions, but then in a practical sense, when they try to come here, they face all these walls.

I know we can't completely open up the floodgates because we have to maintain standards, and we also have to be fair to Nova Scotians. There are lots of Nova Scotians who are choosing these careers as well, and since they've grown up here they deserve priority. I'm sure we could all agree to that. I just say that for the record, because what I'm hearing out there is a lot of frustration from people who are trying to come here. They're hearing that we want them, but then when they actually try to go through the systems, they don't feel that welcome. I just say that as a comment.

The question that comes to my mind, as our world becomes more global - and there are high standards, I'm sure, everywhere in the world for health care systems. We often think we have the best in Canada, but I'm sure there are some in other countries that are just as good and maybe even better. I know I've travelled different parts of the world and I've been amazed at how quickly I have gone in. I remember in one situation in particular, I was in and out in about 30 minutes - I saw a doctor, I had my prescription. I was amazed.

I guess what comes to my mind is, are we moving more toward international standards for physicians? I'm sure anywhere you go in the world we all want to have high standards for people's care. We even look at it in the financial industry - we have securities commissions in every province in the country, but everybody's buying and selling on the Toronto Stock Exchange or the New York Stock Exchange. So, you know, I guess you start to ask why aren't we looking at taking a bigger picture or view of this kind of thing so that we can take down some of these walls? I guess the question I would ask is, why not an international medical standard or perhaps a national medical standard for anybody who's coming to Canada?

DR. LITTLE: Holy crow. Well, first of all, the United States at the moment has made a decision that by the year 2023, no physician will be able to practice in the United States unless they have graduated from a school which is accredited by the Liaison Committee on Medical Education. Canada and the United States jointly accredit medical schools and you'll remember, recently Dal was under a threat of probation from the Americans last year. We accredit all the medical schools in this country – the 17 medical schools - and a huge number in the United States. I can say pretty certainly that there are probably no other countries that have the accreditation system.

Countries are now coming to the United States and to Canada and asking us to participate in accrediting their medical schools. So Egypt has approached the Americans to see if the Americans would come and accredit their medical schools. There are 400 medical schools in India. There are probably as many in China. The Indian Medical Council was just disbanded by the national government for corruption. There were a number of medical schools there that were completely unaccredited but the head of the medical council had

fudged the books and made them look like they were accredited. There are medical schools in the world which have one year curricula.

So it's very, very difficult to get a world standard. There is a world organization that's based in Copenhagen looking at medical education around the world but to get an international standard is going to be very difficult. The Third World is looking to the U.S. and Canada to assist them in going through some accreditation process. So it would be a great idea but, boy, that's a big project.

MADAM CHAIRMAN: Mr. MacMaster, your time has elapsed now but thank you very much. I would like to turn it over to Mr. MacKinnon for the NDP caucus.

MR. CLARRIE MACKINNON: Madam Chairman, it's great to have such outstanding witnesses before us this morning and we're certainly getting some good information.

One of the things that I would like to talk about, I think we do a good job sometimes of recruitment, we do a very, very poor job in retention and I'm wondering what information we actually supply to some immigrant doctors in relationship to the expectations. Some people have grown up in cities many, many times the population of Nova Scotia and we try to attract people to rural areas, which is great, and I don't know what we would be doing in this province without the 30 per cent of foreign doctors, immigrant doctors, that we have.

I think that was the number but what we find is that often the doctor feels fulfilled. The doctor is happy but the spouses are very, very unhappy, both male and female, and I think it's almost like the war brides who came here in 1946, and the expectations. If you came from London or Amsterdam and you ended up in Saskatchewan in the wintertime, 30 degrees below, I think we have to have some kind of information on expectations because it doesn't do anything for the doctors that we attract. It does very little for the local community when several hundred people become attached to that doctor and that doctor is gone after a year and a half or two years. It happens so often and we're left with people without a doctor.

So what can we do in relationship to the expectations and making people feel more welcome as well? That's a problem. We sometimes forget that it's nice to be friendly, but do we invite people over for supper and really make them part of the community? Some comments from anyone?

MS. SHEPPARD KUTCHER: I could start. I think you've hit a really important nail on the head. Spousal employment is a key challenge, and this isn't just for IMGs, this is also for recruiting physicians - Canadian-trained physicians in smaller centres, because they are usually not one individual. They are usually a professional couple. I've seen that kind of situation even with IMGs who have chosen Nova Scotia and want to stay here, and

one of the partners is successfully practicing, the kids are happy in school, they like the smaller community, but the spouse is extremely frustrated.

I think that the smaller communities across the province need to recognize what you've pointed out, that this is not only about recruiting a physician to the community. It's about settling a family effectively in the community, and employers need to be open to the spouse. In our work, we engage with employers very actively and are increasingly doing that across the province, so that's an important step forward, but really that recognition has to come from the community itself. Unless the family is effectively settling in the town or the rural community, retention will be a challenge.

MR. MACKINNON: Another problem, and I just make the comment, is that it's very hard for some immigrant doctors within the institution itself to break into what used to be called the old boys' club, but is now the old boys' and old girls' club, right? That's just a comment. I think staff have to make people feel more welcome and be willing to give the new person a role as well.

MS. SHEPPARD KUTCHER: Just very quickly, Doctors Nova Scotia is the professional association for physicians, and we have tried, over the past number of years, and we have been working productively with Doctors Nova Scotia, but we've broached the idea with them - and I say "we"; it's not just ISIS, but Dalhousie and other partners - of creating an associate membership that would signal a welcome into the profession and would allow them access to supports like the e-Library that is available, and so on. That has not been possible.

I think that the profession, we are moving forward - access to grand rounds in the hospital, the observerships and so on, are indicators of some progress, but again, I would agree with you on that. I think there need to be concrete ways that the profession itself opens the doors and greets IMGs as colleagues and potentially-licensed physicians in the system.

MADAM CHAIRMAN: Mr. McNamara first, yes. You've been waiting.

MR. MCNAMARA: I just wanted to respond in a couple of ways, and I think even when we talk about the number who go through the program, retention is extremely important, even to keep those who we have licensed. From my experience in the past as CEO of a district health authority, I can tell you that the community plays an integral part, and if they're not a welcoming community, individuals will not stay.

I can give you one example of an international medical graduate who is in our community, and the individual felt that her husband had not been invited to anything in that community, so they left because there was no interaction for that spouse, who felt alone.

The second one I can respond to relates to the spousal job. Lynda mentioned one individual who did not complete the program. The reason the individual didn't complete it is that the husband could not get a job locally, so he was in Toronto with two young children and she was trying to go through the program here over a few years. That's very difficult on a family.

One of the things we've done that is trying to help this is, one, having the site visited in advance, to try and help the community become part. The second thing on the spousal job that we are doing, particularly relating with the DHAs, is if there is an issue now with a spouse trying to find a position, we try and look to the rest of government and talk to peer deputies and say, is there a position that they may be able to help to be able to employ the spouse, so that we can try and keep them in the community. We have to continually work on those types of things and quite honestly, the community has to be a partner with us in retaining individuals as much as anything the college can do, the Department of Health and Wellness can do or a DHA.

MR. MACKINNON: One of the things that I hear at a constituency level quite often is why are there not more seats for Nova Scotians. The Nova Scotians who actually graduate, they have no adjusting to do to Nova Scotia. I think of three recent graduates from Barneys River in my constituency, three brothers who have gone through the medical system. They, in fact, know Nova Scotia and there's no adjustment for them.

Just as recently as yesterday afternoon in my constituency office, an activist was in saying, why can't we have more Nova Scotians who qualify, getting into Dalhousie? What really bothers them and the term is "seats for sale", where an oil-rich nation can actually have students coming to Dalhousie and rural people believe that some potential Nova Scotian students are, in fact, being displaced by such action. So comment on that, if you would.

MR. MCNAMARA: The sale of the seats to Saudi Arabia, which are the ones you are referring to, are not taking away from seats for Nova Scotians. The medical school seats that were available for Nova Scotians are the same as last year, the year before and even with the additional ones the Department of Health and Wellness put in. What happened is when New Brunswick set up its medical school students are going into New Brunswick so those seats that were previously sold to New Brunswick, to use that word, are being sold to Saudi Arabia, so it's just taking from New Brunswick, not from Nova Scotia.

The second part you were talking about, in terms of more Nova Scotians, is I assume - I'm not sure if you're referring to those who graduated through the offshore medical schools, is this what you're referring to? Just to clarify the question.

MR. MACKINNON: It could be, yes.

MR. MCNAMARA: Okay, there are individuals who go through other countries to get their medical training, they would be treated as an IMG or international medical graduate, no differently than individuals coming from Poland, for example, so they would have to go through the same process.

Dr. Little can talk about the success rate more than I can but again, they still have to come to meeting the standards of the College of Physicians and Surgeons of Nova Scotia and being able to practice in our culture.

MR. MACKINNON: Deputy, I have a great respect for you and what you are trying to do within the department you are employed with. However, what annoys Nova Scotians is what you've just said, the same number of seats this year as last year for Nova Scotians, the same number of seats as the year before. Why can't we have more seats for Nova Scotians is the question that I am asked repeatedly?

MR. MCNAMARA: I think you have to go to the university and ask them. Quite honestly, I don't decide who gets accepted into medical school. The Department of Education funds Dalhousie for most of the seats. For example, if somebody takes a Bachelor of Arts, they can come from Ontario or from Nova Scotia, depending on how they get into the school. The same for medical seats, it is not the Department of Health and Wellness that is prescriptive and what we're trying to work our way through is the Department of Health and Wellness paid for additional seats. We're trying to figure out did we actually get Nova Scotians into those seats. We're working with Dal to understand that at this current time.

MR. MACKINNON: And the only reason I took your words to task, not the department . . .

MR. MCNAMARA: Oh, I understand that.

MR. MACKINNON: Did we get a promise that we were going to get statistics, not on Canadian students but on Nova Scotian students over the last five years?

MADAM CHAIRMAN: It wasn't specifically on Nova Scotia students.

MR. MACKINNON: Can we get that?

MR. MCNAMARA: We're working - when we get that from Dalhousie we can pass it on.

MS. WHALEN: That would be a request then, thanks.

MR. MACKINNON: Thank you very much. I just want to very quickly - and I was going to share time with the member for Halifax Chebucto but he has indicated to me to

keep going here. What's happening in other provinces with support for provincial students, and are some provinces ahead of us in what they're doing to get more provincial students involved in medical schools?

MR. MCNAMARA: I would say - well, I know that on the average we're better. I know that the other provinces, Ontario and Quebec for example, would be higher, but then again their population is much higher in terms of numbers. I don't have the actual statistics to tell you that.

MR. MACKINNON: I will turn the time over. Over the years I've developed a love for Cuba and have toured a lot of facilities, including medical facilities. I had a good tour of a hospital which was doing great work with a very limited amount of medical equipment and so on. Do we ever reach out to Cuba in relation to attracting doctors, many of them with great training, with great English and so on? When you look at the situation in Haiti, Cuba was able to supply 400 doctors to Haiti within days and a province like Nova Scotia, if we lost one to Haiti we'd really feel it. Is there any opportunity for enticing folks to come here and adjusting to our system?

DR. LITTLE: Well, they can't leave - we do have Cuban physicians in the province. Most of them are doctors that have skipped a fishing boat or come here fleeing the country, but they can't get out. Often they can't even get their credentials - we can't even get those from Cuba.

There are many countries in the world which actually by public policy overproduce physicians. The Philippines, for example, it's a national policy to have way more health care workers - train them - than they can possibly use. The idea is they go away and there are remittances back to the country. Something like one-fourth of the GDP of the Philippines is from remittances from nurses and doctors and various people around the world, and Cuba does the same thing.

The problem was that Cubans went to South Africa and then South Africans were going up into Angola. The South African medical authority had a great deal of trouble with the Cuban physicians because some of the Cuban hospitals were excellent, some of the physicians were excellent, but there's a huge discrepancy and that didn't work out very well. The other issue, of course, is language, and that's a big issue in terms of speaking English here. They can't get out unless the government lets them, and they're now going to Venezuela with Chavez.

MR. MACKINNON: In the Trudeau days we used to be able to work a lot of things out with Cuba, it's too bad we still can't. I'll turn it over to the member for Halifax Chebucto.

MADAM CHAIRMAN: Mr. Epstein.

MR. HOWARD EPSTEIN: Thank you. Actually, I think this question might be for either Mr. McNamara or Dr. Little, I'm not sure. It's a follow-up on what was just asked. I take it that what we operate is, to some extent, a passive system, not one of active recruitment aimed at other nations, or am I wrong?

MR. LITTLE: I can answer that. We feel that our priority is for immigrants who are in this country. There's a big debate going on in the world about whether it's ethical to be recruiting physicians from Third World countries. I think that the WHO has made a statement that if First World countries are going to take physicians from the Third World, we have an obligation to pay them for that and they're suggesting substantial amounts per doctor - maybe half a million dollars - because it takes resources to train those physicians in those countries and it's a brain drain. There's a whole debate about whether or not it's ethical to actively recruit.

I can tell you 10 years ago I was at a meeting of our national organization in which the High Commissioner for South Africa attended and he excoriated us for actively going to South Africa to recruit physicians. It wasn't Nova Scotia but it was Alberta, the Alberta Registrar and Government went to South Africa and they recruited over 100 doctors. South Africa is so desperate right now for medical manpower. This is a big issue about actively going overseas to recruit physicians, is it ethical or not, and should we pay those people something for that?

MR. EPSTEIN: It's a very valid point, and I'm glad you brought it up. It's something I think many of us are aware of. I suppose the other side, of course, is that Canada, like the United States, is a nation of immigrants, and people come here and try to make their way. I was particularly struck by the 30 per cent number that I think was in Mr. McNamara's opening statement - the 30 per cent meaning that 30 per cent of our physicians actually are foreign educated. So what I wondered was how that - and I think you said the number was higher in Nova Scotia than in other provinces as well. I'm wondering what the numbers actually are, more or less, in other provinces, if you happen to know it, and if there's anything in particular that accounts for our numbers being higher than they are elsewhere?

MR. MCNAMARA: We do have a document we can probably table with the numbers.

MR. EPSTEIN: It's fine if it comes later. That's fine. But roughly, are we wildly ahead of other parts of the country?

MR. MCNAMARA: No, as I mentioned, Ontario and Quebec are ahead of us, and I believe Manitoba is ahead of us as well. Those three provinces are ahead of us, but I'm talking a national average. It's about 25 per cent and we're 30 per cent.

MR. EPSTEIN: So not hugely different?

MR. MCNAMARA: No.

MR. EPSTEIN: Okay, that's fine. Now, the next question I have, I actually think is for Dr. Little. I wonder if you could just tell us what exactly the process of evaluation of candidates involves? I was struck by your comments about how difficult it is to actually assess the institutions that they come from, and how challenging that is, given the large number of unaccredited - by North American standards - medical schools there are in the world. Do we take it then that the focus is on the individuals who come forward? And do you, as part of that, try to focus on their institution, or do you simply measure their skills when they come?

DR. LITTLE: This is what we do. Our CAPP is not simply an initial assessment. It's a four-year program. So we take individuals and they have to pass a basic medical examination from our Medical Council of Canada. They have to do that, and they have to have been in practice within at least the last five years, because we know that if they've been out of practice for more than five years, it's unlikely that they're going to be successful, and it's taking the money from them.

So if they come into that, we don't really look very much at where their undergraduate was. They go through this assessment, and then those who are successful, who in other words demonstrate their clinical skills with about 14 patients - common problems that you'll see in Nova Scotia; problems that have been identified by other family physicians in the province as important things - those are successful then. They go to Dalhousie Continuing Medical Education and they get an education prescription for the next year based on their report, their strengths and weaknesses, and they have to fulfill that education prescription.

They have a mentor - and this is going back to one of the other questions. We thought a mentor was very important because that would introduce the physician into the community. We have a practice audit at six months. Then at one year we ask patients, colleagues, and co-workers to give feedback on this physician's performance, and every month the mentor provides us with written feedback on how this physician is doing.

It's a very long process, and then after a year, if they've done well, they don't need a mentor anymore; they continue working in the district and ultimately try to get their Canadian exams. They've all been successful so far. We're probably the only province in which they've been successful in getting a full licence, because we put a lot of resources into helping them succeed. We want them to succeed.

MR. EPSTEIN: All right, I'm afraid my time is up. Thank you very much - a very helpful answer.

MADAM CHAIRMAN: Thank you very much, and we're going to change Chairs.

[Mr. Howard Epstein took the Chair.]

MR. CHAIRMAN: We're going to move to the second round of questioning at this point. I'll do a quick calculation in a minute - I think it's about 12 or 13 minutes, and we move to Ms. Whalen.

MS. WHALEN: If you could just adjust my time, that would be great. I wanted to try and get through quite a few questions, so I'll ask if we can be sort of brief. My first question is for the deputy minister, and I wanted to talk about the clerkships that we offer. There are only two of them right now, which are the third-year programs at Dalhousie. I believe the government does support those programs, but it's a pilot, I think. What I'd like to know is whether there has been any consideration about increasing the numbers. You've had a few years now to look at the success rate and to see how it's working, and there's only two positions available, so could you comment on whether that has been looked at to increase?

MR. MCNAMARA: I'm going to ask Lynda, because she can more appropriately give you the information.

MS. CAMPBELL: It's a relatively new program. The first group only went in 2008, and was such a small number that evaluation is a little bit challenging at this stage. We are monitoring some figures, but I think we want to see, first of all, how well that program works.

MS. WHALEN: Can you say if the initial success is there? I'm hearing good things.

MS. CAMPBELL: In terms of success at the moment, yes, in that those who have entered in have completed on time and they have been successful in the CaRMS match for residency position in Canada. The early indication is good. We'd like to wait and see the success with completed . . .

MS. WHALEN: Do you have a time frame to review it and to look at expansion? Right now it sounds like you're in a holding pattern. Can you just let me know if you're looking at it?

MS. CAMPBELL: We have been talking with Dalhousie about success indicators and what we want to look at. In fact, they have done some preliminary looking with the candidates, at their perspectives, but jointly, we're considering how to evaluate.

MS. WHALEN: I'd love to see that program expanded. I realize it's part of the Department of Health and Wellness' programs, so I'd just like to say I think it's a positive one.

I wanted to ask some questions as well about the Canadians studying overseas. I know it was touched upon by Mr. MacKinnon, but what I'm seeing is a large increase in the numbers of our own Nova Scotian students going overseas - and Canadians, in fact. It's now a business in the Caribbean and other places to attract students to come and pay significantly higher fees to come and study there. Just in my own community, I know of families whose children are studying outside of the country.

What I wanted to know was what avenue they have when they come back to Nova Scotia. My understanding is they would also be vying for seats through the eight seats that the deputy minister referred to in residency, that the province has created - eight for Nova Scotia and two for New Brunswick, I believe. Anyway, I want to know how that's playing out. Is there a great demand from Canadian students in the last few years to take those seats?

DR. LITTLE: I'm not sure I can answer your question. There has been a demand, but this is all done through the Canadian Resident Matching Service - CaRMS - and I'm not that familiar with it. I think I heard somewhere that about 50 per cent are getting matched. That's higher than non-Canadian IMGs.

MS. WHALEN: I guess my point really is that the Canadian students have grown up here. They have the culture, the language and so on, already under their belts, so what we really need to do is find ways to integrate them back in. Has there been any way, or is it something you're considering, to create a separate stream?

We're here today talking about true international medical graduates who have grown up in another culture, another country. Now we have Canadian students who are in fact competing with them for these few spaces in that particular residency program, and there are very few other avenues, as we hear. Is it on the government's radar screen to review that and see that, because this is a new trend and there are so many Canadians trying to come back to Canada with foreign credentials? Are we looking at any other means?

I think it's unfair to the international medical graduates - I mean the immigrant international medical graduates - to have Canadians fighting for those same few positions.

MR. MCNAMARA: Quite honestly, they take training whether it's in the Philippines or in Poland or other countries. Their training is no different, whether they are a Nova Scotian or whether they're someone from another country. Yes, the cultural part and the English part, they do have it better. That gives them the advantage, as I think Dr. Little has mentioned, in going through the residency placement, but the medical training is no different. There is no reason that we would see to lower the standard for a Nova Scotian going to train outside of the country, any different it would be for our expectation of somebody who is from another nationality trying to come into the country.

MS. WHALEN: My suggestion isn't that we lower our standard in any way but just that we have a separate stream so that those Canadian-born students wouldn't be in competition with foreign-born applications and that there might be merit. Also we have Canadian citizens and Nova Scotians who are coming to us saying my son or daughter studied in this country and we want them to come home. Again, they're reading about the shortages in Yarmouth or the shortage in Cape Breton of specialists or whatever it may be so they want to see their young people be able to come back. Dr. Little perhaps you could add to that.

DR. LITTLE: This is a human rights issue too. I think we have to recognize that because they're all citizens here, they're all Canadian whether or not they are from another country or they were born in Nova Scotia. I know that the College of Physicians and Surgeons in British Columbia, about 10 years ago, actually lost to the Human Rights Commission because they were making certain individuals do certain things more than they were making Canadians. I think it's a big issue and we have no control of who goes overseas, there is no control. We don't even know if we need that many physicians because quite frankly, if you have the bucks now you can get a medical degree somewhere in the world.

MS. WHALEN: I understand that and I'm not suggesting different standards. I'm suggesting more residency spaces so that Canadian-born kids aren't taking, say half of those eight spaces that were allocated for the people who have come here from overseas. That's what I'd like to leave on the table with you there is that there is merit in looking at that because this trend is not going away.

I'd like to go briefly to the issue of specialists because the CAPP is designed for family practitioners and generalists. What happens for our specialists who are coming from overseas to make Canada their home? I noticed again, looking at Manitoba that they have a specialist stream called the Nonregistered Specialist Assessment Program, I'm wondering from Dr. Little, or maybe the deputy minister - or maybe Dr. Little is best - to say if there is any consideration being given to establish an assessment program for specialists who are ready to practice.

DR. LITTLE: There are specialists from overseas who are licensable in Canada, we do recognize certain specialty training from overseas and those individuals may be able to be licensed. The difficulty is that we don't do the assessment of these things, we have to use the experts and that's Dalhousie University and it takes a specialist to assess a specialist, you can't just do it in a couple of minutes or a day. It takes a considerable amount of time to know, does this person have the surgical skills to be a general surgeon in Yarmouth and what are the requirements in Yarmouth?

We think it takes at least six months or a year, of assessment or further training, to do that and we're trying to work with Dalhousie University to get a track where we can at least get the specialists such as internal medicine, surgery and psychiatry, some of the

important ones that we're short of in this province to see if we can develop a system with them. But we have to rely on Dalhousie and it takes resources, time and money in order to do that.

MS. SHEPPARD KUTCHER: I just wonder if I could make a comment to that. Six months to one year of assessment is a significant cost, however, I think it's important to keep in mind that at the end of that six months to one year there would be a specialist, a psychiatrist needed in a community in Nova Scotia. If we were to train a psychiatrist from day one we would be paying for four years, minimum, of university education for a Bachelor of Science; an additional four years of medical school for a total of eight; and four to five years of residency training. That would be 12 to 13 years of education the province would be paying for. So looking at the situation from that perspective, paying for six months or possibly a year seems like somewhat of a bargain.

MS. WHALEN: Perhaps I could follow up with the deputy minister on that. Clearly there is value and we have specialty needs, we have gaps and I'm wondering if you can comment about that. I realize we're waiting on your physician resources plan. Which I have to say is overdue because it's really hard to make policy decisions, I'm sure you feel that too, in a vacuum and not know where the needs are the greatest and where they are coming in the future. But could you comment on the need for it because I think we have some significant shortages in specialists.

MR. MCNAMARA: Well, that's one of the things we're not really sure of. We heard anecdotal stories, but what we need to understand is what do we need and where do we need it, and we have to also tie it into a clinical plan so that we know what services are going to be offered where within our province.

We do know that when you have a service you need a cadre of physicians in order to have an on-call rota, to ensure that there are safe procedures in place, so we're working our way through that. When we finish our work this Fall it will give us then a plan to move forward, and then we can see what we should do to fix up the deficiencies and where they exist.

MS. WHALEN: So is there any plan at all to look at more specialists? I guess you have to do it with the college, but would money be available to help implement this as we go forward?

MR. MCNAMARA: What we need to know first is what we need and where we need it, and then we can shift our resources, because we may be putting money into things we don't need. For example, we may be training in the wrong places. We know that we're not using even our incentives to put physicians in the right places. Sometimes we were, for example, paying money for physicians who were considered rural - I mean, we're talking about Timberlea and Enfield, and I don't think they're really rural, looking at where we have our needs.

It's a lot of work to be done, but we need to know where we're going before we figure out how to fix it.

MS. WHALEN: That plan will certainly be welcome. I guess it's coming in the Fall, you said, and hopefully public in the Fall?

MR. MCNAMARA: Probably by January.

MS. WHALEN: I'd like to go back to the CAPP with Dr. Little, if I could. I don't think I have time to get the complete answer, but I'd like to ask . . .

MR. CHAIRMAN: 15 seconds.

MS.WHALEN: . . . for something in the future, then, if you could provide for us information about how the decisions are made on the CAPP acceptance or rejection. It's not really a pass/fail, according to your Web site, but I think it seems very arbitrary, or maybe it is subjective, because I don't know if there's a big report given back to the individual that says how they did. Could you provide it to the committee later?

MR. CHAIRMAN: Again, sorry. I'm going to have to . . .

MS. WHALEN: He needs to cut me off.

DR. LITTLE: I'm not sure. The reports are long. They are very thorough. These are confidential reports that go to the individual, and I'm not sure I can provide you with them.

MS. WHALEN: It's the process I'd like.

MR. CHAIRMAN: Perhaps we had better do an exchange of correspondence on this to nail that one down. I'm going to have to move now to Mr. MacMaster and the next 12 minutes.

MR. MACMASTER: Thank you, Mr. Chairman. What is the demand and supply for physicians each year?

MR. MCNAMARA: That's why we're going through the resource plan, to try and figure out what we really need. Quite honestly, we don't know in this province what number of physicians we need and where we need them and what the accountabilities that we're working through are. For example, I can't tell you with any certainty if we have the right number of pediatricians at the IWK - do we have too many? Too few? I don't have a clue, and nobody can tell us. That's why we're going through this work. Do we have the right number of GPs? We know, for example, in certain communities that they are well supplied by physicians - in some cases, they're over-supplied. We know that in other areas they are very short.

We do know the number of physicians that we've had increasing on a basis and we also know on a per capita basis that we have the highest number of GPs in the country. We also know that we have the highest number of specialists, regardless, even, of our loss. We have an equal number of specialists to GPs, which is higher than any other province in this country. But are they the right specialists? That's the question we need to get to.

[Ms. Diana Whalen resumed the Chair.]

MR. MACMASTER: I can appreciate that we don't really know the number, which kind of causes me concern, but when we're looking at educating people to become physicians or surgeons, are we protecting a certain number of positions each year for Nova Scotians to apply to go into school?

MR. MCNAMARA: No, we're not and that's one of the things we were also talking with Dalhousie about, particularly the health-funded one. I will also tell you that in the next two days I'm meeting with my peer deputies in Gatineau. One of the things is that we are meeting with the deans from across the country to talk about some of the needs that we know we do need. We know, for example, that we need more general internists, rather than sub-specialties. We know that we need more general physicians, rather than physicians who specialize in emergency care. We know, for example, that we need more general surgeons. So this is something we, the deans, are going to talk about: how do we change from going to so much sub-specialty into the needs that each of the provinces have? This is not just for Nova Scotia. It's a country-wide issue.

MR. MACMASTER: Okay, and that brings me to my next question. I can appreciate if you can't answer, but I guess my next question would be, how many new immigrant physicians or surgeons would we be trying to target each year to help supply our demand for those positions?

MR. MCNAMARA: Once we have our physician plan, then we'll have an idea of what we need from local graduates plus international medical graduates and have a plan to work toward.

MR. MACMASTER: And this may be a question for the College of Physicians and Surgeons, is one of the goals of accreditation to control the supply of physicians and surgeons?

DR. LITTLE: No, the accreditation is to ensure that they get a good medical education. It's there to make sure the universities have the resources to give a good medical education, a curriculum which is up-to-date and has been reviewed, enough teachers and enough counselling for medical students, all of those kinds of things. That's what goes into the accreditation and so we have a very uniform accreditation in this country. The curricula are a little bit different from university to university but we know that the graduate who

comes out of a Canadian university has a very narrow band in terms of where they are. So that's with the accreditation - to ensure that they get a good medical education.

MR. MACMASTER: Who determines the number of seats each year in Nova Scotia, seats for people who can become a physician or a surgeon? Would that be the universities that would determine that or is it in conjunction with the college?

DR. LITTLE: It has nothing to do with us.

MADAM CHAIRMAN: Mr. McNamara, did you want to add anything to that?

MR. MCNAMARA: One of the things is, well, first, medical seats are set up by Dalhousie and funded mostly by the Department of Education. A number of years ago it was announced that there were additional seats funded by the Department of Health which we are working our way through. One of the difficulties, it looks like there may have been money passed over for the seats but I'm not sure the accountability was there to guarantee that they would be Nova Scotian seats. So that's one of the things that we're working our way through now.

MR. MACMASTER: Okay. One of the things, of course, we all understand the importance of having the technical expertise to be a physician or a surgeon. What measures do we have to look at people's attitude, their personality, their compassion for people? Is there some way that we measure people on that basis based on their actions?

DR. LITTLE: Well, that's a question really for the university but the admission process is based on a number of things. It's based on your marks, your GPAs and various things. It's based in some provinces on how you do on this sort of M-CAPs, the medical examination prior to going to medical school. Now I think in this university and in most across the country they have what are called sort of mini-interviews in which the students are given a scenario or faced with a situation, not a medical situation, but how to address that problem and do it in front of others, or how to co-operate with another student to do this interview.

So people have done that. People have talked about doing psychological testing. The problem is it all comes down to – are these things valid and how do you show that they're valid and how do you know that this individual is going to come out a really good doctor or a crumbum and it's a crapshoot, quite frankly. So we just go on what we have right now.

MR. MACMASTER: And I guess one of the reasons I'm thinking about this is if we're looking at international medical graduates coming to Nova Scotia, culture plays such an important role and how people interact. Sometimes it may not be intentional but you may have somebody, there may be certain people, or people from certain parts of the world

who may be a better fit for Nova Scotia. I guess we've probably never done any research into that, have we? I wouldn't expect.

MR. MCNAMARA: Perhaps I can answer that. No, I don't think but I think individuals from all countries can qualify to be Canadians and can fit into our culture. For some it may take a bit longer because of understanding the language and also we do know that there are practices that are different, that we would be working with them. I think that all individuals can learn, all individuals can change. For some it may be easier to be compatible, that's fair, but I think my belief on individuals in this world is that with the appropriate amount of mentoring and training they can be appropriate and work with us and provide good medical care regardless of where they come from.

DR. LITTLE: I would turn that around, I think Canadian physicians also have to become more understanding of immigrants, right. I mean if you go to Toronto, about 50 per cent of the population there was born outside of Canada. There are 250,000 Tamils in Toronto. There are 200,000 Egyptian Christian Copts in Toronto.

These are huge communities, and it's important that we have both physicians from those communities and people like me who also have some understanding and some cultural awareness of those communities. I think it's a mixture of everything, really.

MADAM CHAIRMAN: Good point.

MR. MACMASTER: I'm glad to hear you say that, because I love to travel and I go to different places in the world, and you go into a country where they don't speak English very much and you realize how your little accents and your little colloquialisms from where you come from, even within the province here - you don't realize that they exist until you get into another country. I guess the purpose of that question was just to try to see if there was any focus on that. For somebody coming here to adjust that would be significant, and of course, if we invite people here we want them to actually have a good fit here and for things to work out for them.

I think somebody else would like to make a comment.

MS. SHEPPARD KUTCHER: I think that the languages and the knowledge of culture that IMGs bring to medical practice is a value-add, particularly as our population becomes more diverse, as Dr. Little has alluded to. We also work in a variety of ways, though, to assist IMGs who are keen to understand the culture of health care practice in Canada. In our organization and in a variety of other ways, we try to assist them to learn the cultural norms and practices and how to interact effectively with patients.

There is a lot of information that's not in the textbooks that relates to ethics and general practices and regulations and so on. There's a great deal that IMGs need, and they

need access to situations and training and information in order to learn that. They certainly can learn that and can be very effective.

One final thing is just that in my many years of working with IMGs, I would say that of language, culture, place of origin, et cetera - the most overriding predictor of success is personality. There is a variety of personalities amongst Canadian-trained physicians, as there is amongst IMGs.

MR. MACMASTER: Exactly. One of the other things I think we've talked about today is the difficulty - while we have a challenge getting people to serve in rural Nova Scotia as physicians and surgeons, I can think of somebody who is coming here from another country who has the cultural adjustment to make, but if they grew up in an urban area, they'd also have to adjust to living in a rural area in a country that's maybe very different from where they grew up. I don't know if you have any comment on that.

MS. SHEPPARD KUTCHER: I have a brief comment, and that is that it would be impossible to be an immigrant without having the ability to adjust, to be adaptable, to be flexible, to be a lifelong learner, to be able to set goals and work toward those goals. I have every confidence in IMGs' ability to adapt to new situations, because they've demonstrated it simply by virtue of taking on the massive challenge and adventure of immigrating to Canada.

MR. MACMASTER: Thank you. I certainly agree with that, but I should say, because I've seen it even around home, that we've had people immigrate to the area and they've moved on because they wanted to live in a city. Life is very different in little places like Judique, where I come from, and we certainly try to do everything we can to welcome them. You're right, they are adaptive, but at the end of the day people are going to go where they feel most comfortable, and if they're a little more comfortable in Toronto or somewhere - I know the Deputy Minister of Health and Wellness wants to comment, and I'd like to hear his comments. I would also ask him if he could include this in his comments: should we be trying to encourage Nova Scotians who are here to serve maybe in the rural areas, to free up some more positions in the urban areas for people who might be international medical graduates, if we have a shortage of supply coming from within our own province?

MADAM CHAIRMAN: Mr. McNamara, there are just a few seconds left, so if you could be brief?

MR. MCNAMARA: Very quickly, just to have people serve in rural communities is difficult. As a matter of fact, we're having difficulty even with nurses who are graduating from Dalhousie University. They do not want to move to rural areas. They're writing letters saying they have no jobs, when there are actually jobs available, but they say that's not Halifax.

Secondly, in terms of our incentives, what we'll be working through at the end of our physician manpower plan is how we use what incentives we have to help people move toward rural communities - some of it's in our master agreement already, but to enhance that and make it more enticing for individuals to go enter service in rural communities.

MADAM CHAIRMAN: Your time has elapsed now, so I would like to invite Mr. Whynott to have the questions for the next 12 minutes.

MR. MAT WHYNOTT: Madam Chairman, I just want to ask Mr. McNamara on some of your opening comments, I just want to get some clarification, if that's fine.

You talked about Nova Scotia having 231 physicians per 100,000 of population, saying that it's the highest overall rate of physicians in Canada. When I talk to constituents and I tell them that stat, they are very surprised at that. Can you explain very briefly - I don't know if it's a brief comment or not, but briefly on why that is?

MR. MCNAMARA: Well, I think there are a number of factors, and I'm talking pure statistics; I'm talking numbers. I don't think it recognizes the number of part-time physicians who may play a part in it. We also know, and I think it is fair to say, that we have one of the highest numbers of female physicians, who practice differently as well because of being involved in family responsibilities, so that may change how the factor is.

We also know that most of our family physicians practice what I call "old bankers' hours" - they are available from 9:00 a.m. to 3:00 p.m. or 9:00 a.m. to 4:00 p.m. Some of them do after-hour calls, depending on the community, but it's access that is our biggest problem. It may not be the number of physicians. That's why we're developing the community emergency centres, so we can have same day or next day access and be able to have other professions to be involved with the physicians to provide a wider area of service to Nova Scotians.

One of the areas we're looking at for the future, and we're not sure it's a sure-go, is whether a physician assistant might be a possibility in some communities when the new Act passes through the Legislature. This would also provide opportunity for international medical graduates. I know that's one of the things that is used in Manitoba, that they work in those areas, so there might be other opportunities as we develop new programs.

DR. LITTLE: I think there's one other thing, too, and that is that we are a tertiary care centre for the three Maritime provinces, so a certain amount - I don't know what the amount would be, but there's a certain amount of care given to New Brunswickers and P.E.I.'ers in Halifax here, at the university and the QEII, so that increases the numbers also, I think.

MR. WHYNOTT: Sure, thank you. Mr. McNamara, you also said that about 30 per cent of the doctors in Nova Scotia are IMGs, which is above the Canadian average. It

puzzles me to - I guess, why are people coming to Nova Scotia and wanting to set up a practice? Why not the bigger centres, like Toronto or Vancouver?

MR. MCNAMARA: Well, if you use numbers, they're going in greater numbers to Ontario and Vancouver, but we're doing okay in terms of percentage of our total physician population. That's what I'm talking about.

You have to remember that many of the physicians we have who were international medical graduates have been around with us for a long time. There was a change in the rules a number of years ago, too, which changed how people came into the system. They go through a new assessment, and that has made changes as well. It's more difficult now than it was 10 years ago.

MR. WHYNOTT: I actually have a constituent of mine who e-mailed me three months ago or so. He was visiting family in England, and a family member was a doctor and was interested in coming to Nova Scotia. What would be the first point of contact for someone who would want to come to Nova Scotia to set up a practice? Would it be the Department of Health and Wellness (Interruption) Immigration, okay.

MR. MCNAMARA: Immigration first, obviously, and then the College of Physicians and Surgeons for understanding what qualifications and standards they would need to meet in order to be able to practice here.

DR. LITTLE: We can't license people who are not citizens or permanent residents, so they'd have to go through Immigration, but again, they could certainly ask for a review of their credentials, to see if they would be licensable if they were to come here, or what they would be required to do.

MR. WHYNOTT: Okay, thank you. I'm going to share my last few minutes with Mr. Skabar, who wants to ask a quick question, I believe.

MADAM CHAIRMAN: Mr. Skabar.

MR. BRIAN SKABAR: You mentioned, Dr. Little, that there are some - the Philippines, in particular, and Cuba, by matter of public policy - who produce more medical practitioners than they would need locally. If you don't mind, I'd like to hear a bit of an editorial on that. To me, that doesn't necessarily seem like a bad thing, to have enough locally-produced medical practitioners to meet your own needs and perhaps export.

DR. LITTLE: I'm not criticizing that at all. There's a recent article in The Economist, I think two weeks ago, with exactly that point, is that this is in some ways good for those countries. It brings back money, it brings money back into the country from overseas, and also if people are able to move, it encourages people to go into those fields in

those countries that actually can raise the general education level in some of those countries. So that's not a bad thing.

The problem is that it's difficult for me to say, but it's maybe the difference between a reasonable dog breeder and a puppy mill. I mean eventually, if you produce so many physicians, do you have the resources to really give them a good basic education in medicine and training in medicine? There's only so many people who live in that country, you know, and medicine isn't just an education, it's at least two years of training, and for a specialist a minimum of four in Canada, and maybe six years, and you have to see a lot of disease, you have to see a lot of patients in order to do that.

If you have huge numbers of students, often they don't get any patient contact or very little patient contact and that's why many of them actually want to come to Canada. Medical students overseas, they want to come here and do electives here because they can actually get some hands-on patients and learn first-hand. So it's not a bad public policy, I'm not criticizing it, I'm just saying that it's very difficult to know the quality of many of those individuals. Italy has 30,000 medical students who are unemployed, not practicing. Medical education is free. You get your medical education and then you hope you get some further training but you might not. They have 30,000 unemployed medical students in Italy.

MR. SKABAR: Well, that being said, that's where you come in to make sure that the medical practitioners we have here do meet the standards and we have every confidence, you know, in the college that that's going to happen. I understand the concept of like a puppy mill compared to a dog breeder and, producing more people who have a degree that says they're a doctor than are really capable and competent. That being said, do we have more capacity? From where I'm sitting, and again mostly rural Nova Scotia, access is an issue.

DR. LITTLE: Well, we have as much capacity as we have. If we want more capacity, we've got to invest in the capacity. It's like everything, you have to invest in it, you know, if we want more capacity to assess IMGs, we need more resources. That's all. We need more trainers, we need more faculty, we need more money to set up assessment programs and that sort of thing, but all of those things can be done. We're demonstrating we can do it. It's just how much do you want to invest in it?

MR. SKABAR: As much as it takes is how much. Yes. You also mentioned that Nova Scotia is the only province where the college determines the assessment of the IMGs and other provinces at the universities?

DR. LITTLE: No, no, the universities run the programs. We're the only organization, the only college that runs the program. In the other provinces it's paid through the university, by government through the university. We were the biggest supplier of IMGs to the University of Manitoba up until we started the CAPP. Then we

were told by the university there that the government had told them that they weren't to take any more people from outside of Manitoba to assess and so we said, well, what are we going to do? So our organization invested $0.5 million. The doctors of Nova Scotia reached into their pocket, each one of them for $200, and we set up the CAPP so that we could carry on and try to assist some of these IMGs but we were shut out of Manitoba.

MR. SKABAR: That's all I had, thank you.

MADAM CHAIRMAN: Were there more questions? Mr. Epstein. You have a couple of minutes – until 10:57 a.m.

MR. HOWARD EPSTEIN: Yes. I think this is for the deputy minister and we've been discussing IMGs, of course, as a very important aspect of our overall physician needs, and I'm thinking about your 10-year projections in the project that you're working on now. There are two things that I wonder about that. One is, if we're just doing this now, what on earth have we been doing before in terms of our understanding of what our physician needs are? The other is, I wonder if you're planning on doing it for the other allied health professions that require a high level of education, like nurses, lab techs, and medical technicians. It's probably a long answer, but let's take a whack at it.

MR. MCNAMARA: There has been some work done on the other professions - maybe not perfectly, but at least some work. In the case of physicians, it hasn't been done in this province. In fact, country-wide, the only province that has a physician manpower plan is P.E.I. There are some districts or parts of provinces that have done it, and based on the work that was done in P.E.I., we felt it was important that we do this in Nova Scotia.

For example, right now, if you are an individual who goes to medical school in Nova Scotia, you can graduate, you can set up a practice wherever you want, see as many patients as you want, as frequently as you want, and send the bill to the government. That's really the plan that has been in place. We've got to put some rigour into that so that we can understand what we need and how we entice people to go to the right places.

It's the same, for example, we're looking about whether we can expand the growth to some of the other health professions to help in some of our rural communities, but we want to do it in a way so that we don't end up providing more services in the wrong areas of our province. It's a lot of work that has to be done to do it right. I can't speak for the past. I can just say that we've taken this on as something that we believe is the right thing to do in order to be able to put a path forward.

MR. EPSTEIN: So other provinces haven't done formal studies along these lines?

MR. MCNAMARA: Other than P.E.I., no, not as a full province.

MR. EPSTEIN: That's stunning. So when provinces have thought about their overall physician needs, whether by GP or specialists or overall numbers, they've relied on general statistics and a sort of gut instinct? Is that what we've been looking at?

MADAM CHAIRMAN: I'm afraid your time has elapsed now. We had started a couple of minutes late, but we're now into our closing statements. The time has elapsed for questions. Mr. MacKinnon, did you have a comment?

MR. MACKINNON: Just on a point for information, if I could. We did hear that the number of Nova Scotians admitted to medical school was the same as last year and the same as the year before. In the supplying of the information for the last number of years, and going back for as far as we can go, the information that I think we should be requesting is not when the person actually entered medical school. I think we should be looking - and the information would be available at Dalhousie - at the high school, the point of entry into university from high school, from Nova Scotia. There is a fundamental difference. Someone could be listed as a Nova Scotian graduate of the medical school and actually have had a Nova Scotia address upon entering medical school. If we can go back 20 years, I'd appreciate that.

MADAM CHAIRMAN: Twenty years - I put "as far as possible," but we'll try twenty years. Thank you. I think now is the time for our closing statements. Mr. McNamara, did you have any comments you'd like to make?

MR. MCNAMARA: Just very shortly, I want to thank the committee again for having us here. I think one of the things we do have to spend a lot of time on is how do we retain those that we do have going into the program? We also need to invite and ensure our communities work with us, as well the many agencies, particularly those that are here with us today. We are committed to ensuring that we provide good, safe, medical health care to Nova Scotians, and we'll work hard to do that.

MADAM CHAIRMAN: There is not much time, but we did start late, so if you had a few minutes, Ms. Sheppard Kutcher - if you'd like to say a few words?

MS. SHEPPARD KUTCHER: I have included in a package some suggestions - 10 suggestions for going forward. I think innovative thinking is needed. This is a tough challenge that really requires us to think outside the box, look at self-funded options, et cetera.

I'll ask you to consider that IMGs have chosen Nova Scotia as their home. They are Nova Scotians by choice rather than by birth, but nevertheless are Nova Scotians. They want to contribute their skills and knowledge to the health care system here. Their medical education, their post-graduate training, has been actually subsidized by other countries who are beneficiaries of that, and the training gaps they may encounter and the bridging

mechanisms needed could be seen not as a cost but as an investment in the health care system.

If Nova Scotia is going to accept international medical graduate physicians as immigrants, if we're going to open our doors, I believe we have a moral obligation to ensure that there are realistic, fair and accessible routes to licensure, while still maintaining the standards that are required. To do otherwise would result in a lose-lose instead of what I think is a potential tremendous win-win for the province. Thank you.

MADAM CHAIRMAN: Thank you very much. Dr. Little, did you want to say anything? I know you didn't do an opening statement.

DR. LITTLE: I was going to comment on a couple of things. The biggest thing for physicians is, I think for most people, can your partner or spouse work? The education of your kids and a vibrant economy, that's part of the reason why physicians choose to go where they do.

The real problem with the manpower issue is that you have no control over what doctors do. It is sort of like the Ford Motor Company, everyone wants to be a painter or everyone wants to work on the assembly line but not distribute. They decide what they want to do, how many patients they see, the type of practice they have, whether or not they are delivering mostly non-insured services, et cetera. So it's very difficult to get a handle on what the needs are because you have no control over what the worker does.

Anyway, those are my closing comments and I also would like to thank you for inviting me. I didn't think you'd be asking me as many questions as you have but there you go, thanks.

MADAM CHAIRMAN: Thank you very much to all of you and it is a subject that is of great interest, I know, to all of the members of the Legislature and I think important to our province as well. So we look forward to the physician resource plan which will perhaps provide some more guidance around where we go in future.

Thank you very much to all of you and on the committee business there is no new business, just a note that we have our last meeting of the year next week, on Wednesday, here. A motion to adjourn, please.

MR. MACKINNON: So moved.

MADAM CHAIRMAN: Thank you. We are adjourned.

[The committee adjourned at 11:02 a.m.]