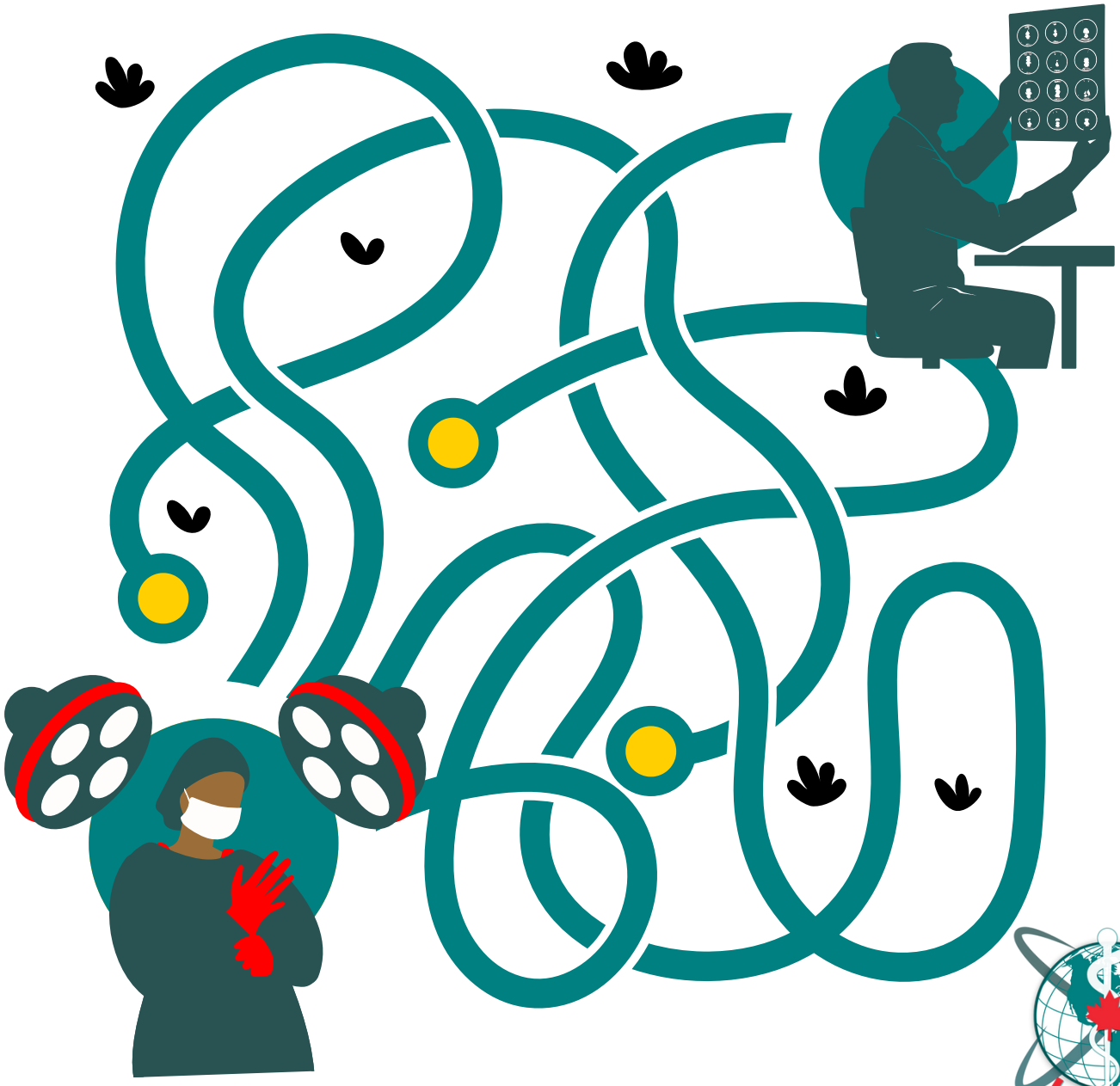
ACCESS TO LICENSURE FOR SPECIALIST ITPS: A LABYRINTH OF BARRIERS; ACTIONABLE SOLUTIONS



A Research Report by the Policy, Advocacy, Research Committee
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List of Abbreviations

ACGME: Accreditation Council for Graduate Medical Education
AP: Associate Physician
CA: Clinical Assistant
CAC: Certificates of Added Competence
CaRMS: Canadian Resident Matching Service
CFPC: College of Family Physicians of Canada
CMG: Canadian Medical Graduate
CPSO: College of Physicians and Surgeons of Ontario
FM: Family Medicine
GP: General Practitioner
IMG: International Medical Graduate
ITP: Internationally Trained Physician
MCC: Medical Council of Canada
MCCQE: Medical Council of Canada Qualifying Examination
MRA: Medical Regulatory Authority
NAC: National Assessment Collaboration
OBGYN: Obstetrics and Gynaecology
PER: Practice Eligibility Route
PGME: Post-Graduate Medical Education
PRA: Practice Ready Assessment
RCPSC: Royal College of Physicians and Surgeons of Canada
SEAP: Subspecialty Examination Affiliate Program

Preface

About ITPC

Internationally Trained Physicians of Canada (ITPC) is a federally incorporated non-for-profit organization founded in 2021, with a vision to enable Internationally Trained Physicians (ITPs) to contribute to the Canadian healthcare system, as doctors, upholding principles of equity, diversity, and inclusion. ITPC engages with key health sector stakeholders and proposes innovative evidence based solutions for the integration of ITPs into the healthcare system, as doctors. We provide free practical support at various licensure stages, and support ITPs currently training or practicing in the Canadian healthcare system (1).

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Executive Summary

Specialist ITPs are physicians who have completed residency training in a country outside of Canada in a specialty other than Family Medicine. Canada currently faces a severe shortage of several specialties in areas of need, and Canadians wait longer than most high-income countries for consultations with specialists (2).

This report shows that specialist ITPs are diverse, experienced and highly skilled. With training from **45 countries** around the globe, almost **90% of the respondent ITPs have more than three years of specialist training**, and **over half have more than five years of independent clinical practice** in their specialty area. Although skilled ITP specialists have various pathways available in Canada, a labyrinth of barriers prevent most of them from accessing licensure; these barriers however are not without actionable solutions.

This report will showcase i) disjointed and non-uniform processes, ii) lack of transparency and adequate guidance from official resources, and iii) issues with eligibility criteria which prevent knowledgeable, qualified, specialist physicians from participating in Canada's clinical workforce. There is a lack of collaboration across health system stakeholders. The impact of this fragmentation has consequences for Specialist ITP licensure and ultimately healthcare access for Canadians.

Barriers include General Barriers and Pathway-Specific Barriers.

The major General Barriers are:

1) Inequity and Discrimination
2) Navigation and Misinformation
3) Financial Burden
4) Recency of Practice
5) Access to documents, Redundancies and Inefficiencies

The major Pathway-Specific barriers are:

1) Mismatch between approved jurisdictions and countries that ITPs immigrate from
2) Rigidity in training assessment/eligibility/selection criteria that do not capture ITP strengths and competence
3) Lack of facilitation and support through licensure pathway
4) Limited opportunities/positions/spots
5) Cumbersome processes that lack transparency

Actionable solutions include:

1) Expansion of available positions in all licensure pathways and facilitation through the process

2) Flexibility in assessment/eligibility/selection criteria in order to capture ITP strengths and competence and supplemental pathways used as adjuncts as necessary
3) Creation of a regulated Associate Physician role that ladders into an independent licensure pathway to support the regaining/maintenance of recency of practice
4) Mandated anti-bias and anti-discrimination training
5) A collaborative taskforce between immigration and licensure bodies
6) Financial grants for the licensure journey

Review our detailed recommendations below in Solutions to Incorporate ITP Specialists in the Healthcare System.

Introduction

Canada is experiencing a specialist care shortage. Wait times for consultations and procedures exceed those of other high-income countries (2). The median wait time between a general practitioner's referral and specialized treatment is 30 weeks, but in the longest cases, it can take up to 77.4 weeks (3). While these delays can exacerbate pain and patient suffering, many specialists experience moral distress as they are unable to provide the care their patients need (4)(3),(4). The shortages are even more severe in rural and remote areas due to an imbalance in physician distribution across the country (5). At the same time, an aging physician workforce and a growing population are further straining the system (6),(7).

ITPs represent a significant yet underutilized segment of the Canadian healthcare workforce. They currently make up 25% of medical specialists and 16% of all surgical specialists in the country, bringing extensive clinical experience from diverse healthcare systems worldwide (8). Fully integrating ITP specialists into the system could help alleviate workforce shortages and improve access to care, especially in high-demand specialties.

Despite their potential contributions, ITP specialists face numerous barriers to practicing in Canada. The pathways to licensure are disjointed, non-uniform across provinces, and often lack transparency. Eligibility criteria are restrictive - some requiring recency of practice or Canadian experience that many ITPs struggle to obtain. Financial constraints, limited residency spots, and a lack of support in navigating the system further hinder their ability to contribute to the workforce.

This report explores the role ITP specialists could play in addressing shortages and the systemic barriers that prevent their full integration. It also presents potential solutions, including expansion of available positions in all licensure pathways and facilitation through the process; flexibility in assessment/eligibility/selection criteria in order to capture ITP strengths and competence and supplemental pathways used as adjuncts as necessary; and creation of a regulated Associate Physician role that ladders into an independent licensure pathway to support the regaining/maintenance of recency of practice.

By implementing these changes, Canada can better utilize its diverse and skilled ITP workforce to enhance healthcare access and patient outcomes.

Becoming a Specialist Physician through Canadian Training

On a national level, postgraduate medical training and certification are regulated by two Colleges in Canada: The Royal College of Physicians and Surgeons of Canada (RCPSC), which governs medical and surgical specialties and subspecialties (9), and The College of Family Physicians of Canada (CFPC), which regulates Family Medicine (10).

To become an RCPSC specialist physician in Canada, one has to complete a Bachelor's degree (four years), a Medical Degree from an accredited medical school (3-4 years) and specialized residency training (4-5 years) in their chosen field. In addition, successful completion of the certifying examinations conducted by the RCPSC and obtaining a license from the Medical Regulatory Authority (MRA) is necessary (11,12). MRAs are provincial and territorial bodies, like the College of Physicians and Surgeons Ontario (CPSO), responsible for granting physicians licenses to practice within their jurisdiction (13,14).

After completing residency training in a particular field, specialist physicians can undergo additional training through sub-specialty residency or fellowship (1-3 years) (12). These are more specific and concentrated areas within broader medical specialties. For instance, after finishing a residency in Internal Medicine, physicians can pursue further training in subspecialties such as Adult Cardiology, Adult Nephrology and Adult Palliative Care (15).

Some family physicians practice similar specialist roles in Canada, namely in Emergency Medicine, Addiction Medicine, and Palliative Care. These physicians first undergo a 2-year training in Family Medicine and then complete a Certificate of Added Competence (CAC) (16). It is important to note that a family physician can also work in these fields of medicine without CAC. In this report, we focus on RCPSC specialists. For other recommendations regarding integrating ITPs in primary care, see our previous reports (17–20).

Current Pathways for ITP Specialists in Canada

ITPs can pursue different pathways to licensure in Canada, depending on factors such as where they completed their residency training, their level of experience, and the province or territory in which they intend to practice. Each province or territory MRA establishes its own requirements for licensure.

An important bit of conceptual understanding is the difference yet relatedness between certification and licensure. Certification of specialists is done by the RCPSC in Canada. For family physicians, with additional specialist competencies, a certificate of added competency is issued by the CFPC. Certification speaks to the attainment of a certain standard set by the certifying organisation.

Medical Regulatory Authorities (MRAs) use certification as one requirement for licensure. In some cases, ITPs are able to gain certification prior to licensure, which typically leads to an independent licence to practice. In other cases, this is difficult. Some pathways allow for the issuance of a licence to practice with some conditions placed, prior to certification. This report will show the difficulties ITPs face in gaining certification prior to licensure and the difficulties faced in accessing pathways that allow for a limited/restricted licence to practice prior to certification.

In this section, we will describe the various certification and licensure pathways available to ITP specialists across Canada such as RCPSC pathways, practice ready assessments, residency, and academic licensure.

RCPSC Pathways

The Royal College of Physicians and Surgeons of Canada (RCPSC) is the official certifying body of specialists in Canada. The following pathways therefore represent a path to certification. Becoming certified is a significant step toward achieving licensure.

Approved Jurisdictions/Programs
(including ACGME Route and International Residency Programs Accredited by RCPSC)

ITPs may qualify for this route if they:

- Completed accredited specialist training in an approved jurisdiction in an approved program in that country. There are currently eight countries approved by the RCPSC: Australia, New Zealand, Hong Kong, Singapore, South Africa, Switzerland, Ireland, and United Kingdom (14); or
- Completed part or all of their specialty training in an U.S.A-based specialty program accredited by the Accreditation Council for Graduate Medical Education (ACGME) (21) (ACGME Route).
- Completed their training in an international residency program accredited by the RCPSC. There are currently only 6 programs around the world that fall into this category and only for graduation in recent years (after 2017) (22)

Approved jurisdictions/programs have two steps that ITPs must complete to obtain certification by the RCPSC:

1. ITPs must submit their credentials to the RCPSC to ensure that their experience and time of specialty training are equivalent to the Royal College requirements in their discipline.
2. After they are granted eligibility, they must pass the RCPSC exam within five years (13).

The Approved Jurisdictions for medical specialties are intricately nuanced, and not all medical specialties and subspecialties receive approval in each jurisdiction (14). The detailed eligibility criteria for the jurisdiction-approved route to licensure in Canada can be seen in **Appendix A.**

If ITPs are successful at step one, they receive a letter of ruling of eligibility to take the RCPSC examination in their specialty. With this letter, in many provinces ITPs are able to receive a restricted/defined licence to practice from the MRA, for example in Nova Scotia (23), Ontario (24) and many other provinces. Failure to pass the examination results in the licence being revoked.

PER - Practice Eligibility Route

ITPs may qualify for this route if they:

- Completed their specialty training outside Canada, the US, and the RCPSC-approved jurisdictions in a program not accredited by the Royal College; and
- Completed training in a Royal College-recognized primary specialty; and
- Have experience and time of specialty training equivalent to the RCPSC requirements in their discipline (14).

The PER process has three steps that ITPs must complete to obtain certification by the RCPSC:

1. ITPs must submit their credentials to the RCPSC to ensure that their experience and time of specialty training are equivalent to the Royal College requirements in their discipline.
2. After they are granted eligibility, they must pass the RCPSC exam within five years to practice as specialists in that particular province or territory.
3. In addition to passing the Royal College specialty exam, ITPs must complete a minimum of two years of continuous independent practice in Canada in their primary discipline. In some cases, the time in practice requirements can be met with one year of independent practice and one year of practice during other postgraduate clinical training such as fellowship. ITPs must obtain a license to practice in Canada with each province or territory MRA where they intend to work.

The issuance of a restricted licence using the PER is now possible in all Canadian provinces (25), including Ontario as of February 2025 (26), which was previously the only province not offering this route. The PER is designed for those who fulfill the prescribed training, which varies for different specialties. The eligibility requirements for PER are detailed in **Appendix B**. A successful application to the PER does not guarantee Royal College certification, it only grants access to the RCPSC examination. Importantly, for those who are not successful at this exam, their provincial restricted licence is revoked.

Subspecialty Certification/Affiliation

(including SEAP (Subspecialty Examination Affiliate Program), PER-SEAP (Practice Eligibility Route - Subspecialty Examination Affiliate Program) and PER Sub)

Internationally trained subspecialists in Canada who lack RCPSC certification in their primary specialty may be eligible to apply for assessment through either the SEAP or the PER-SEAP.

ITPs may qualify for SEAP route if they:

- Are registered in a postgraduate medical subspecialty training program (or higher specialty training) accredited by the RCPSC; and
- Are not Royal College certified in their primary specialty.

ITPs may qualify for the PER-SEAP route if they:

- Are licensed and have been continuously working as a subspecialist for at least two years in Canada; and
- Are not Royal College certified in their primary specialty.

Similarly to PER, this route requires five years of independent practice, including 24 continuous months of practice in Canada. In some cases, the time of practice in Canada can be met with one year of independent practice and one year of practice during other postgraduate clinical training such as fellowship.

The SEAP and PER-SEAP routes do not lead to certification by the RCPSC, but instead an affiliate status. ITPs must complete two steps to obtain an affiliate status in the Royal College subspecialty:

1. Submit their credentials to the RCPSC to ensure that their experience and time of subspecialty training are equivalent to the Royal College requirements in their subspecialty; and
2. After they are granted eligibility, they must pass the RCPSC subspecialty exam within five years.

These programs are approved for obtaining a license to practice in a specific subspecialty (not the broader clinical field) in some provinces such as Alberta, Ontario, Nova Scotia and British Columbia (27–30). Failure to pass the required subspecialty examination results in the licence being revoked.

PER Sub (Practice Eligibility Route Subspecialist)

ITPs who have:

- Royal College certification in their primary specialty

- and have practiced a recognized subspecialty independently for at least 5 years, including 2 continuous years in Canada (or 1 year of Canadian practice + 1 year of clinical fellowship), may apply for this route.

A successful application means only that you can sit the RCPSC subspecialty examination. If passed, it grants certification in the subspecialty but not the primary specialty. Once approved, applicants have 5 years to pass the subspecialty exam.

Currently accepted for licensure in Alberta (AB), Ontario (ON), Nova Scotia (NS), and British Columbia (BC) for independent practice in that specific subspecialty. Failure to pass the exam, results in the licence being revoked.

Other

Additional pathways to Royal College certification exist, such as Practice Ready Assessment (PRA), which is under the purview of medical regulatory bodies and therefore discussed separately below.

Some of the major barriers we will demonstrate with regards to Royal College pathways in which certification may lead to licensure are:

1) A lack of adequate information and navigation assistance.
2) Limited approved jurisdictions, marginalising a large proportion of the Canadian immigrant population.
3) Rigid standards to the assessment of training that are based on program structure rather than competencies gained.
4) No alternative path after assessment of training has been unsuccessful.
5) Difficulty finding jobs with a restricted licence for those that get their training successfully approved through the PER route (the only route that most are eligible for).
6) A lack of adequate preparation material for the RCPSC examination.

Practice Ready Assessment

Specialist PRA program eligibility varies by province but is usually reserved for ITPs who are not eligible for the approved jurisdiction route to RCPSC certification (31) . Regulatory bodies within each province assess the postgraduate training of the ITP to determine the level of alignment with the relevant Canadian training and additional factors such as practice experience, language proficiency, work eligibility and in some cases currency of practice. Once accepted, ITPs must engage in a field/workplace-based assessment.

PRA programs consist of a 12 to 24-week clinical workplace-based assessment. Throughout this period, participants work under the supervision of experienced physician assessors to showcase their preparedness for Canadian healthcare practice. After completing the assessment, successful candidates are granted a licence by the MRA and commit to a Return of Service (RoS) agreement, usually serving in high-need areas within the province where the

assessment took place (32). Detailed PRA specialty requirements for each province are available in **Appendix C**.

Currently, all provinces, with the exception of Prince Edward Island, offer individual PRA programs for family physicians (32). PRA specialist programs exist in at least four provinces (AB, MB, QC, NS) but have very small intakes and capacity and remain unknown to many ITPs (31,33–36). Other specialist assessment routes that exist in other provinces are even more obscure. There is a lack of transparency as to what specialties are being considered and accepted and at what time. Unlike family medicine PRAs in which there is usually a structured cohort intake which may have defined application times or rolling applications, the PRA specialist intake process is much less transparent.

Once a licenced is obtained from the MRA, the ITP can achieve RCPSC certification as follows:

1. The MRA or accredited medical school in the province or territory where the ITP intends to practice must send a referral letter to the RCPSC;
2. Once a referral letter is received, a member of the Royal College Credentials Unit contacts the ITP to provide further instructions. Similarly to the PER process, the RCPSC will then review the ITP credentials to ensure that their experience and time of specialty training are equivalent to the Royal College requirements in their discipline;
3. After the ITP is granted eligibility by the Royal College, they must complete a clinical workplace-based assessment;

If the ITP succeeds in the assessment, they will be eligible for the Royal College exams, which must be taken within five years. Failure to pass the examination results in the licence being revoked.

Some of the major barriers we will demonstrate with regards to PRA pathways for ITP specialists are:

1) Limited assessment opportunities
2) Lack of transparency and navigation information
3) Difficulty finding a sponsor/supervisor
4) A lack of adequate preparation material for the RCPSC examination.

Residency

ITPs may qualify for this route if they have successfully passed the Medical Council of Canada Qualifying Examination (MCCQE) Part 1 and the National Assessment Collaboration (NAC) Examination. ITPs apply for postgraduate medical residency positions through CaRMS (Canadian Resident Matching Service), an independent, not-for-profit organisation that facilitates the application and matching process for medical training nationwide by providing a

centralised system for all medical graduates to apply for residency positions via various streams (37).

ITPs can apply for residency through a dedicated stream for ITPs (called the IMG stream) or via competitive streams that are open to both Canadian Medical Graduates (CMGs) and ITPs (38). In the 2024 CaRMS Main Residency Match, CMGs had 3,298 positions designated to them, while ITPs had only 407, with only 191 being for specialties other than Family Medicine. In the 2025 CaRMS Main Residency Match, the number of positions for ITPs in specialties other than Family Medicine had a modest increase to 218. In most provinces, the requirements for ITPs stipulates that physicians must abide by a Return of Service (RoS) contract at the end of their training, usually practicing in other areas outside the major metropolitan centers for two to five years (39). In Ontario, RoS for all residency training programs (irrespective of length) is five years (40).

The table below (**Table 1**) shows seat allocation for CMGs and ITPs in all disciplines across Canada in the 2025 CaRMS Main Residency Match (41). Competitive seats are illustrated for Quebec only, as they are exclusively offered to bilingual candidates. With a high percentage of ITPs not fluent in French, it leaves a small percentage of candidates eligible for competitive seats. Seats for ITPs are available across Canada; however, as the table shows, they are proportionally far fewer than those for CMGs. This makes the likelihood of success, not at the mercy of competition, but instead improbable. Additionally, some disciplines offer zero seats to ITPs, forcing ITPs to reconsider their preferred specialisations if they wish to stay in Canada.

***Table 1**. Seat allocation for CMGs and ITPs in the 2025 CaRMS Main Residency Match*

Discipline	**CMG seats**	**ITP (called IMG) seats**	**Competitive seats in Quebec**
Anesthesiology	118	11	34
Anesthesiology - Clinician Investigator Program	2	0	0
Cardiac Surgery	10	0	3
Dermatology	20	2	10
Diagnostic Radiology	63	4	23
Diagnostic and Clinical Pathology	8	2	0
Diagnostic and Molecular Pathology	23	8	9
Emergency medicine	82	7	10

General Surgery	75	9	15
Hematological Pathology	4	1	0
Internal Medicine	349	70	148
Medical Genetics and Genomics	7	1	5
Medical Microbiology	6	2	0
Neurology	46	13	13
Neurology - Pediatric	6	1	2
Neuropathology	4	1	0
Neurosurgery	20	1	2
Nuclear Medicine	5	0	6
Obstetrics and Gynecology	78	9	18
Ophthalmology	29	1	13
Orthopedic Surgery	50	8	12
Otolaryngology-Head and Neck Surgery	25	2	9
Pediatrics	118	25	31
Pediatrics - Clinician Scientist and Investigator Training Program	2	0	0
Pediatrics - Research Track	1	0	0
Physical Medicine & Rehabilitation	26	1	5
Plastic Surgery	23	0	5
Psychiatry	143	29	47
Psychiatry - Research Track	4	0	0
Public Health and	1	3	8

Preventive Medicine			
Public Health and Preventive Medicine including Family Medicine	14	2	0
Radiation Oncology	21	1	4
Urology	26	3	7
Vascular Surgery	9	1	4
Total	1418	218	443

Some of the major barriers we will demonstrate with regards to Residency admission for ITP specialists or those ITPs wishing to become specialists are:

1. Inequity and inadequacy of residency program positions
2. Inappropriate selection criteria that do not appreciate the ITP context or capture ITP strengths

Academic Licensure

Academic licenses are granted to ITPs who are qualified to undertake teaching, research, and clinical responsibilities.

The academic license in Nova Scotia is granted to physicians sponsored by the Dean of Medicine at Dalhousie University for teaching, research, and clinical responsibilities (42,43). In Alberta, ITPs with a full-time academic appointment at a Faculty of Medicine in the province can register for an academic license with the College of Physicians and Surgeons of Alberta (44). In British Columbia, academic registration is granted to ITPs appointed to an academic position at the University of British Columbia Faculty of Medicine, including assistant professor and clinical professor (45). In Quebec, ITPs recruited as professors by a Faculty of Medicine can apply for a restrictive license with the Collège des Médecins du Québec (46). In Ontario, a parallel academic licensing option is available. It requires an employment offer from a university, which then requests an academic license to the CPSO. A prerequisite for this pathway in Ontario is that the postgraduate training closely aligns with RCPSC or CFPC standards (47).

Besides being available in only five provinces (42,43),(44),(45), these positions are typically challenging to obtain and limited in number, often requiring personal connections and active engagement in scholarly pursuits, such as advanced academic degrees (e.g., a PhD), fellowships, and publications. For example, in Nova Scotia, 93 academic licenses were issued in the first quarter of 2023 (not exclusively to ITPs), while 89 licenses were issued in the same period in 2024 (48), demonstrating the limited number of such licenses granted.

Academic licensure pathways are not suited to a broad range of ITPs and while ITPs are affected by the limited opportunities available, this report will not delve deeper into this pathway.

Other Provincial Initiatives

In recent times, in response to health workforce shortages, new initiatives to improve access to licensure for ITPs have come into place in different provinces. These may be variations on the pathways mentioned above, for example, the PRA program in Nova Scotia was remodeled to PACE (Physician Assessment Centre of Excellence) with a different intake model (49), PRA programs have dropped certain examinations, like the MCCQE1, as an eligibility requirement for example in British Columbia (50), and Alberta no longer requires physicians from approved jurisdictions to complete any assessment to be issued a licence (51). Initiatives may also be distinct from the usual pathways, and true innovations such as the PEI-McMaster Collaborative (52).

These initiatives are young and therefore difficult to assess. However, a few things can be noted.

1. Innovating new ways to incorporate ITPs is a positive direction.
2. However, the focus should be shifted to systemic change and not only a select few
3. Inequities continue to exist in which countries of training are given clear pathways to licensure, creating dead-ends for the majority of the immigrant ITP specialist population in Canada.

The Benefits of Improved Pathways for Specialist ITPs in Canada

ITPs represent 27% of the physician workforce and account for one in every four medical specialists in Canada. They also account for 31% of family physicians and 16% of surgical specialists (8).

ITPs offer diverse representation, similar to recent immigration patterns to Canada. According to data published by Immigration, Refugees and Citizenship Canada (IRCC), in 2022, India was the leading source of recent immigrants, followed by the Philippines, China, Syria, Nigeria, Pakistan, France, and Iran (53). This correlates well with the findings from our survey, where over one in three respondents trained in one of the main countries of immigration to Canada.

In addition to helping with long term health workforce sustainability, helping reduce wait times for specialist physicians, being more cost-effective, and quicker than training new specialists in Canada, the inclusion of ITPs also contributes to the diversification of healthcare. Diversifying the workforce can improve the healthcare system and patients' trust and satisfaction, enhance access to healthcare for marginalized communities, and ultimately improve health outcomes. Furthermore, this may improve representation in leadership positions, thus contributing to the structural changes in the healthcare system (54).

1. Succession Planning in Canadian Healthcare: Aging Physicians and Population Growth

The projected population growth in Canada, which could double by 2074 (6). This highlights the need for increasing the number of clinicians to maintain a sustainable healthcare system. The age distribution of physicians in Canada shows that the majority (44%) are between 40 and 59 years old, with 42,579 out of 97,384 physicians in this group. Additionally, 24% (23,607) are aged 60 or older. Given that the average retirement age is 69, approximately one-fourth of all physicians could retire within the next decade, and 68% within the next 30 years. Similar trends are observed among both family physicians and specialists (7) (Table 2). This highlights the urgent need for succession planning and the recruitment of younger physicians. ITPs can contribute significantly to this need.

***Table 2**. Physician age distribution in Canada*

Age	< 40	40–59	≥ 60	Unknown	Total
Family Physicians	13,356 (28%)	20,514 (43%)	11,358 (24%)	2,609 (5%)	48,264
Specialists	14,407 (29%)	22,065 (45%)	11,822 (24%)	826 (2%)	49,120
All	27,763 (28%)	42,579 (44%)	23,607 (24%)	3,435 (4%)	97,384

2. Reducing Wait Times

Canadians experience longer wait times for non-emergent care than other high-income countries (2). Strategically increasing the number of specialist physicians can positively impact wait times to specialized care, and promote a more equitable and efficient healthcare system. It can also address the current “brain waste” - underutilization of skills and education among highly educated immigrants - which many ITPs experience in Canada.

In 2024, the wait time from a family medicine physician referral to a specialist increased from 14.6 weeks (2023) to 15 weeks. This is the longest wait time recorded in history and is 222% longer than in 1993, when it was just 9.3 weeks. Moving from the consultation with a specialist to the point at which the patient receives treatment, the wait time increased from 13.1 weeks in 2023 to 15.0 weeks in 2024. This is 6.3 weeks longer than what physicians consider to be clinically “reasonable” (8.6 weeks) (3).

Persistent delays in accessing essential medical care have far-reaching consequences. Beyond mere inconvenience, these delays can exacerbate pain, prolong suffering, and heighten mental distress. In some instances, extended wait times may even transform treatable conditions into chronic, irreversible ailments or permanent disabilities. Additionally, patients often bear the financial strain of lost wages during these waiting periods, impacting not only individual finances but also society at large (3).

3. Accelerated Integration of Specialists

Another advantage to incorporating already trained ITP specialists into the Canadian healthcare system is the difference in the amount of time and training needed for independent specialist practice. In Canada, most medical and surgical specialties require a minimum of five years or more of post-graduate training (12). On the other hand, in Manitoba, it takes 4-13 months for a competent ITP to become an independent licensed specialist via Practice Ready Assessment (PRA) (35) and in Alberta, it takes six months (34). This shorter duration is due to ITPs’ significant qualifications and experience in their specialty. The shorter timelines can help remediate acute shortages of specialists quickly and effectively.

4. Cost Savings

There are significant expenses involved in training new residents in Canada, even if they are already competent, skilled physicians elsewhere. In 2013, Health Canada bore a cost of $83,435 per ITP-resident in British Columbia (55). In 2024, this amount was increased to approximately $150,000 per year per resident in the province. This expenditure accumulates over the course of multiple years for medical specialty residency training (56). Increasing the number of ITPs in Canada through pathways other than residency can ultimately result in cost savings for the government.

5. Enhanced Cultural Competence

There is growing acknowledgment of the importance of a diverse workforce to achieve excellence in medicine. Studies have emphasized the increased vulnerability of underrepresented minorities, especially when confronted with language barriers and inadequate cultural competency of healthcare providers (57). This can be addressed by incorporating more ITPs from various cultural backgrounds into the system. Most ITPs in Canada speak more than one language, often including languages that are common among the largest immigrant communities in Canada (17,53).

The evidence goes beyond language barriers, shedding light on the positive impact of racial concordance on health outcomes (58). Various factors contribute to communication challenges between racial and ethnic discordant providers and patients, including cultural differences in health beliefs, values, physician-patient relationships, biases, racism, and language barriers (59). When patients and physicians share the same racial or ethnic background, both parties express higher satisfaction levels, leading to better patient adherence to treatment plans. This is especially valuable when considering that physicians from underrepresented minorities play a direct role in enhancing access to care in marginalized and underserved areas (60).

6. Inclusive Leadership and Policy Development

Besides the clinical workforce, integrating a diverse pool of physicians in leadership and academic roles can promote a deeper comprehension of obstacles to care and heighten the probability of successful patient advocacy. Such integration has the power to impact decision-making, policy formation, and research priorities that directly impact the health of varied populations (61).

Methodology

This report is based on the findings of a two-phase research project designed by the members of ITPC's Policy, Advocacy, Research (PAR) committee. Participants in the research project volunteered their time without any compensation. The research team met regularly to discuss data and findings, and all authors agreed on the final results presented in this report.

The research project was promoted on social media and distributed via email to members of organizations that support ITPs, namely ITPC (62), Alberta International Medical Graduates Association (AIMGA) (63), the Society of Canadians Studying Medicine Abroad (SOCASMA) (64), National Newcomer Navigation Network (N4) (65), and Internationally Trained Physicians Access Coalition (ITPAC) (66).

The first phase was an online survey that included 10 questions focusing on diverse specialists from different countries, areas of specialization, years of training and experience. We collected data from 27 October to 30 November 2023. Out of 117 total respondents, 106 were eligible for analyses as they were considered specialists in their respective countries. House officers, family physicians and general practitioners, or those who did not complete their medical residency were excluded from the survey to specifically focus on specialists.

The second phase was an online semi-structured interview that included 10 open-ended questions focusing on the specialist ITPs' experiences in navigating pathways that lead to clinical practice in Canada and the barriers they faced. Out of the 27 total interviewees, 26 had completed residency training and were considered specialists in their respective countries. Therefore, they were eligible for analyses. Data collection for the second phase took place between May - September, 2024.

Descriptive statistics were produced for close-ended questions, and for open-ended questions qualitative descriptive analysis was utilized. Qualitative data was coded and themes were analysed to produce evidence-based recommendations.

Findings and Discussion

Background of Specialist ITPs in Canada

Country of Training

The diverse training backgrounds of the 106 respondents, spanning 45 countries across six continents, highlights the global scope of medical expertise among ITPs. The largest proportion of respondents (29.3%) received their training in Asia, with India (11), Bangladesh (8), the Philippines (6), and Pakistan (4) being the most represented countries. Additionally, the Middle East and Latin America each accounted for 19% of respondents, with Syria (7) and Iran (5) leading in the Middle East and Brazil (5) and Venezuela (5) in Latin America. Africa, where 13% of the respondents were trained, saw Nigeria as the most represented country with seven respondents. The global diversity of the training locations of these professionals reflects a wealth of clinical experiences and knowledge that can significantly contribute to Canada's healthcare system.

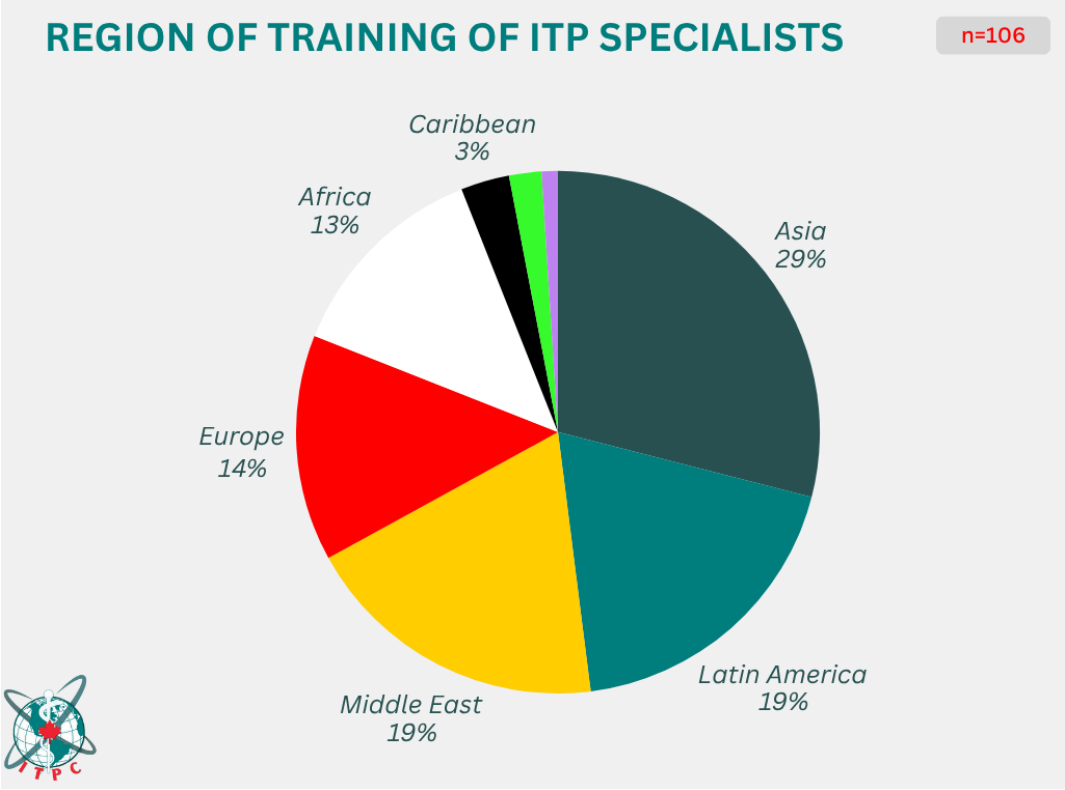

Figure 1. *Region of training of the participants (n=106)*

Numbers of participants: India (11), Bangladesh (8), Nigeria (7), Syria (7), Philippines (6), Brazil (5), Egypt (5), Iran (5), Venezuela (5), Colombia (4), Pakistan (4), Argentina (3), Cuba (3), Russia (3), Saudi Arabia (3), Ukraine (3), Belgium (2), Lebanon (2), Peru (2), Turkey (2) and (1 respondent each from): Australia, Algeria, Armenia, China, France, Honduras, Hong Kong, Iraq, Jamaica, Mexico, Moldova, Mozambique, Nicaragua, Poland, Qatar, Serbia, Slovakia, South Africa, Sri Lanka, Sweden, Taiwan, Thailand, United Arab Emirates, United Kingdom, United States. Six of the respondents had training from more than one country.

Areas of Specialisation

Our survey respondents represented 124 different specialties, being 122 recognized by the RCPSC (67). Fifteen individuals reported having more than one specialty and/or subspecialty. Most common specialties (out of 124) included Internal Medicine - 15 physicians (12.1%), Obstetrics and Gynecology - 14 (11.3%), Pediatrics - 12 (9.7%), Anesthesiology - 10 (8.1%), and General Surgery - 9 (7.3%).

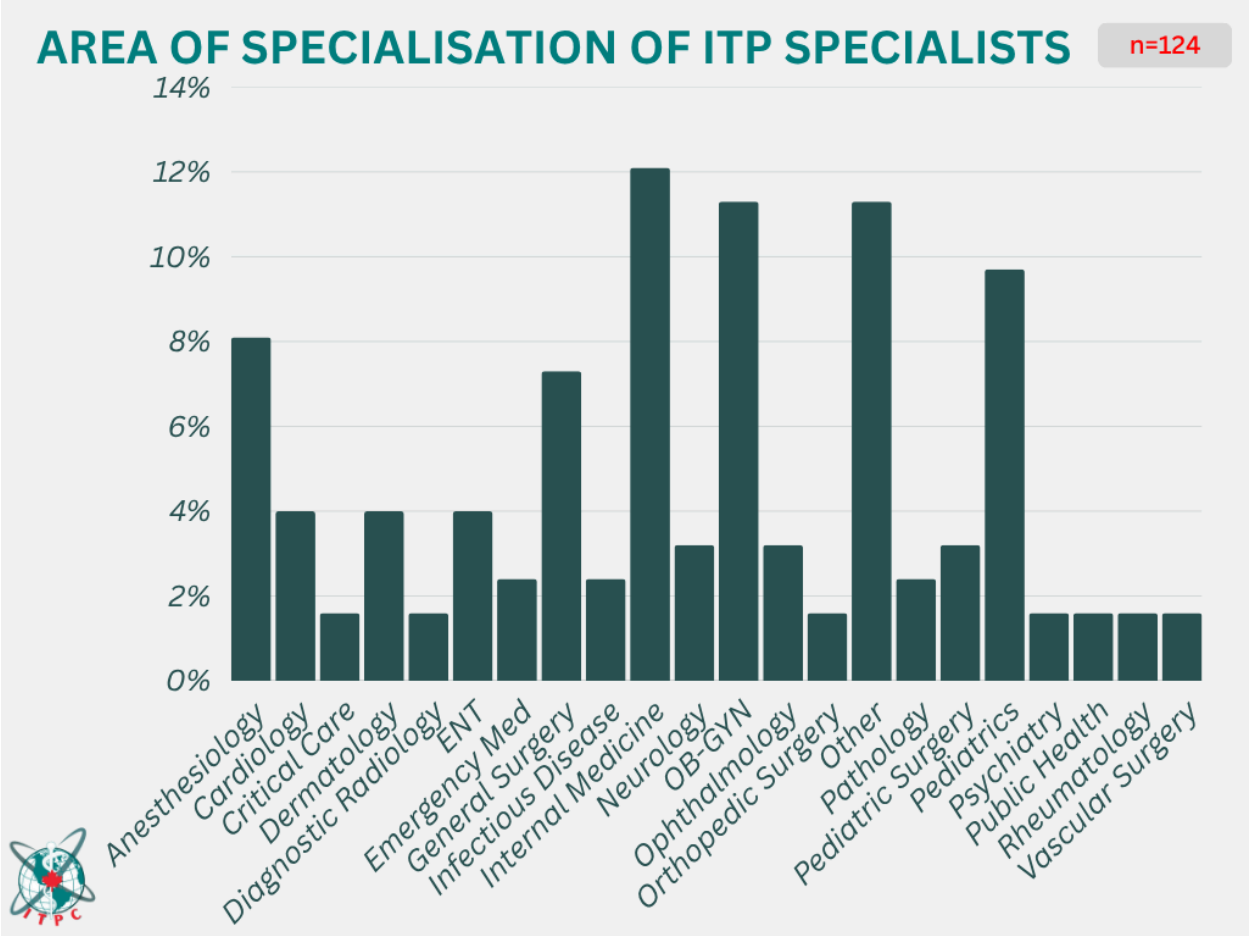

Figure 2. *Areas of specialisation of the participants (n=124)*

Other: Cardiac Surgery, Hematology, Medical Nutrition, Neonatology, Occupational Medicine, Oncology, Thoracic Surgery, Toxicology, Trauma Surgery, Urology.

The distribution of the responses shares similarities with Canadian trends. According to the most recent (2023) data from Scott's Medical Database (SMDB) and published by the Canadian Institute of Health Information (CIHI), there are 35,541 clinical specialists in Canada. The clinical specialty with the largest number of physicians is Psychiatry, with 5,816 physicians, followed by Internal Medicine (4,277), Anesthesiology (3,905), and Pediatrics (3,539). Among surgical specialists, there are 11,505 surgeons. Obstetrics and Gynecology leads the surgical specialties with 2,546 physicians, followed by General Surgery (2,221), Orthopedic Surgery (1,842), and Ophthalmology (1,382) (68).

We also find evidence that ITPs are trained in many of the high-demand specialties across Canada. In 2024, the longest national wait times for specialist care were in Orthopedic Surgery and Neurosurgery (3). In British Columbia, for example, according to the positions offered in the competitive medical residency stream pilot for the 2025 CaRMS cycle, critical shortages are in Emergency Medicine, Internal Medicine, Neurology, Neurosurgery, Orthopedic Surgery, Psychiatry, Urology, and Diagnostic Radiology (69).

Gaining a Specialist Designation

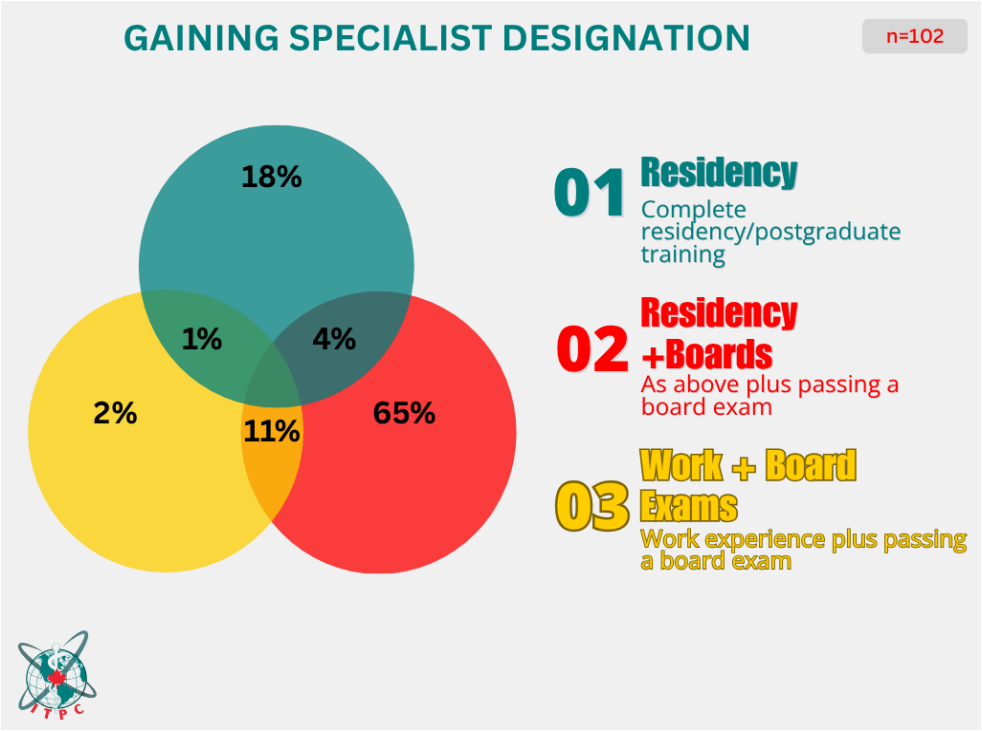

Figure 3. *Attaining specialist designation (n=124)*

Our respondents met different prerequisites to be considered specialists in their respective countries. According to the data collected, 66 out of 102 respondents (64.7%) had to complete

residency and pass a board exam in their countries of training, 18 out of 102 (17.6%) had to only complete residency, while two out of 102 (1.6%) respondents had to work in the respective field for minimum years and pass the board exam after that. In addition, 11 respondents had to work in the field for a minimum of years then pass a board exam and complete a medical residency/postgraduate training and pass a board exam; 1 had to complete a medical residency/postgraduate training and work in the field for a minimum of years and then pass a board exam.

Length of Specialty Training

The total years of training required for each specialty vary considerably across countries, and simply comparing training duration may not accurately reflect a physician's level of expertise. Nevertheless, it remains a relevant parameter and is also part of the PER pathway criteria.

Of the 105 participants who answered this question, 78.1% (82) had 3–5 years of training (excluding medical school and a broad-based internship), followed by 13.3% (14) with 1–2 years and 8.6% (9) with six or more years.

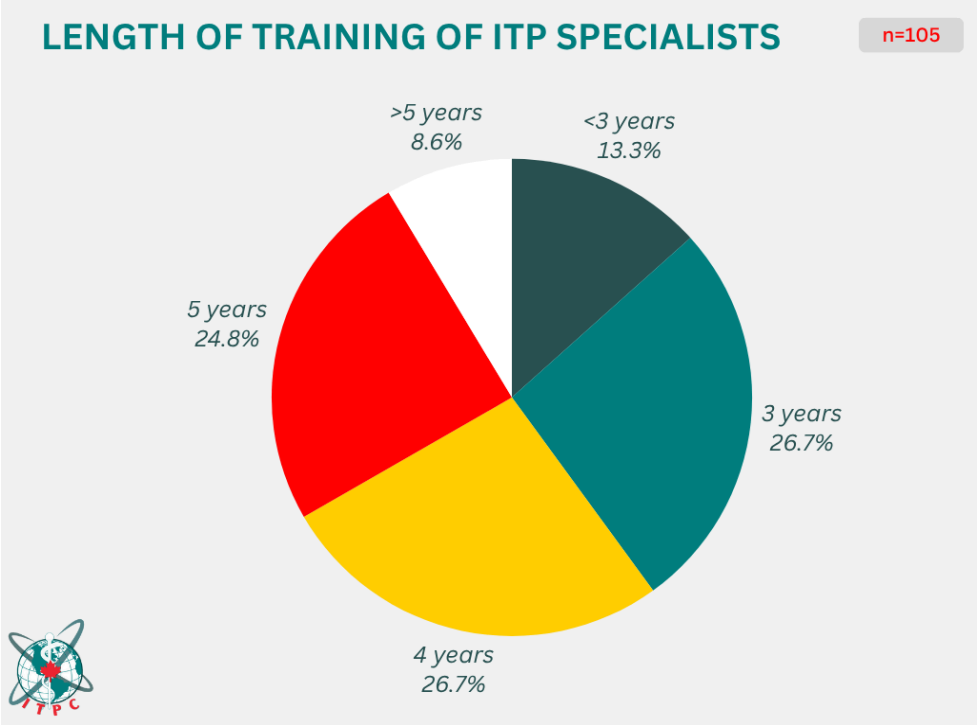

Figure 4. *Length of specialty training (n=105)*

Many countries such as Pakistan, India, Iraq, Iran, Sri Lanka and Libya have a one-year broad-based internship that is mandatory to be able to work as a fully licensed GP (19). After

that, the individuals have a choice to either pursue further specialty training or work as a GP (70). Of note, in some countries such as Nigeria, medical school graduates, after one year of internship, have to complete a one-year period of compulsory community service in which doctors are posted to remote areas (71).

Worldwide, those who desire further specialization training go into a residency which is typically 3-5 years. For example, in Pakistan, Internal Medicine, General Surgery, Anesthesia, Obstetrics and Gynecology, Pediatrics, and Psychiatry all require four years of specialty training with three board examinations. Other routes towards specialist licensure include completion of a two-year diploma and the degree known as membership in the National College, also requiring two years of specialized training. The programs available are Dermatology, Anesthesia, Clinical Pathology, and Pulmonology (72).

In India, for example, a postgraduate diploma in different specialties can be earned after two years of training. Another pathway is a three-year master degree in areas such as General Surgery (Master of Surgery), Internal Medicine (Master of Medicine) or Obstetrics and Gynecology (Master of Surgery in Gynecology), and then for subspecialization further training of 1-2 years is required (73).

The standard medical program in Canada is four years in length, following the completion of an undergraduate degree. This program leads to the awarding of a Doctor of Medicine (MD) degree. After that, physicians enter residency programs. The duration of residency is determined by the chosen specialty (74). For example:

1. Medical Specialties:
    - Internal Medicine: 3-4 years, with additional years required for subspecialties (e.g., Cardiology or Gastroenterology, which each add 2-3 years).
    - Psychiatry: five years.
    - Pediatrics: four years, with further subspecialization adding 1-3 years (e.g., Pediatric Oncology or Neonatal/Perinatal Medicine).
    - Dermatology: five years.
2. Surgical Specialties:
    - General Surgery: five years, with subspecialties such as Thoracic Surgery or Pediatric Surgery requiring an additional two.
    - Neurosurgery: six years.
    - Orthopedic Surgery: five years.
    - Plastic Surgery: five years (75).

Years of Experience

Clinical real-life experience and patient responsibility are often advocated as an optimal way to prepare medical trainees for life as a physician (76). Our survey highlights the significant experience ITPs have, which encompasses a relevant parameter for preparedness to work as physicians in Canada. Out of 99 participants who answered the respective question, the majority (36.4%) had more than 10 years of experience after completion of their postgraduate training. This was followed by 19 participants (19.2%) with 5-10 years of experience and 19 participants (19.2%) with 3-5 years of experience. Fifteen physicians (15.2%) had less than one year of experience and two (2%) had no experience.

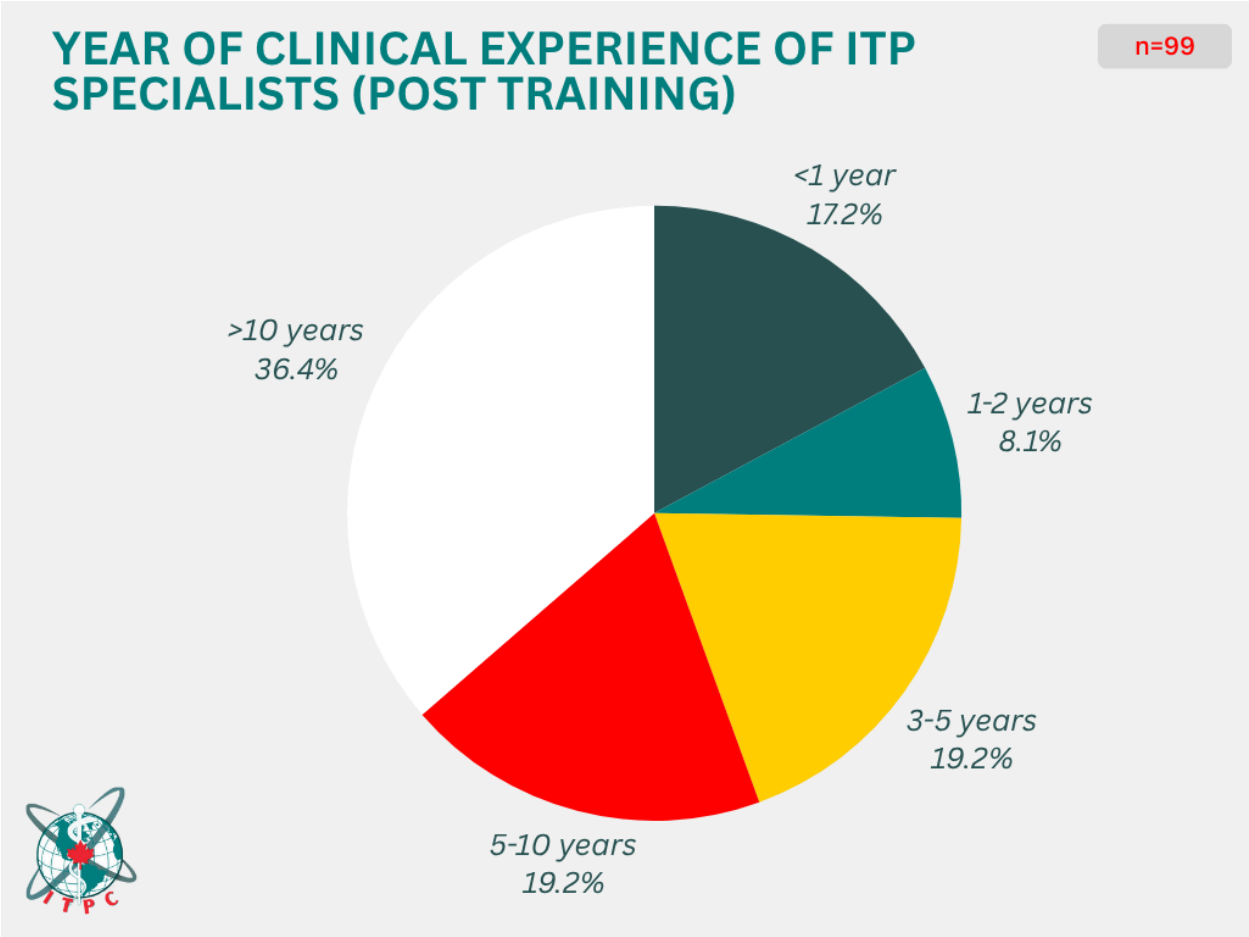

Figure 5. *Years of experience as a specialist (n=99)*

The current pathways for full licensure for ITPs do not place enough value on this vast experience. For example, recency of practice - a requirement in some pathways - is an arbitrary criteria that does not consider various aspects of the ITP, including interim activities and

previous number of years of experience. Additionally, older graduates are often not provided enough opportunity for residency through CaRMS. This, however, does not align with the selection of the most prepared candidates available, as experiences offer knowledge, skills and competence to handle complex and challenging cases efficiently (77–79).

Working as a General Practitioner

It is common in many parts of the world for specialists to have general practice experience due to the broad-based internship and/or community service requirement.

Out of 106 respondents, 72 (67.9%) had experience working as both a GP and a specialist. Out of these 72 participants with dual experience, 39 respondents (34.1%) would prefer to work either as a GP or a specialist, while five (6.9%) would prefer to work as a GP, and 28 (38.3%) would prefer to work as a specialist.

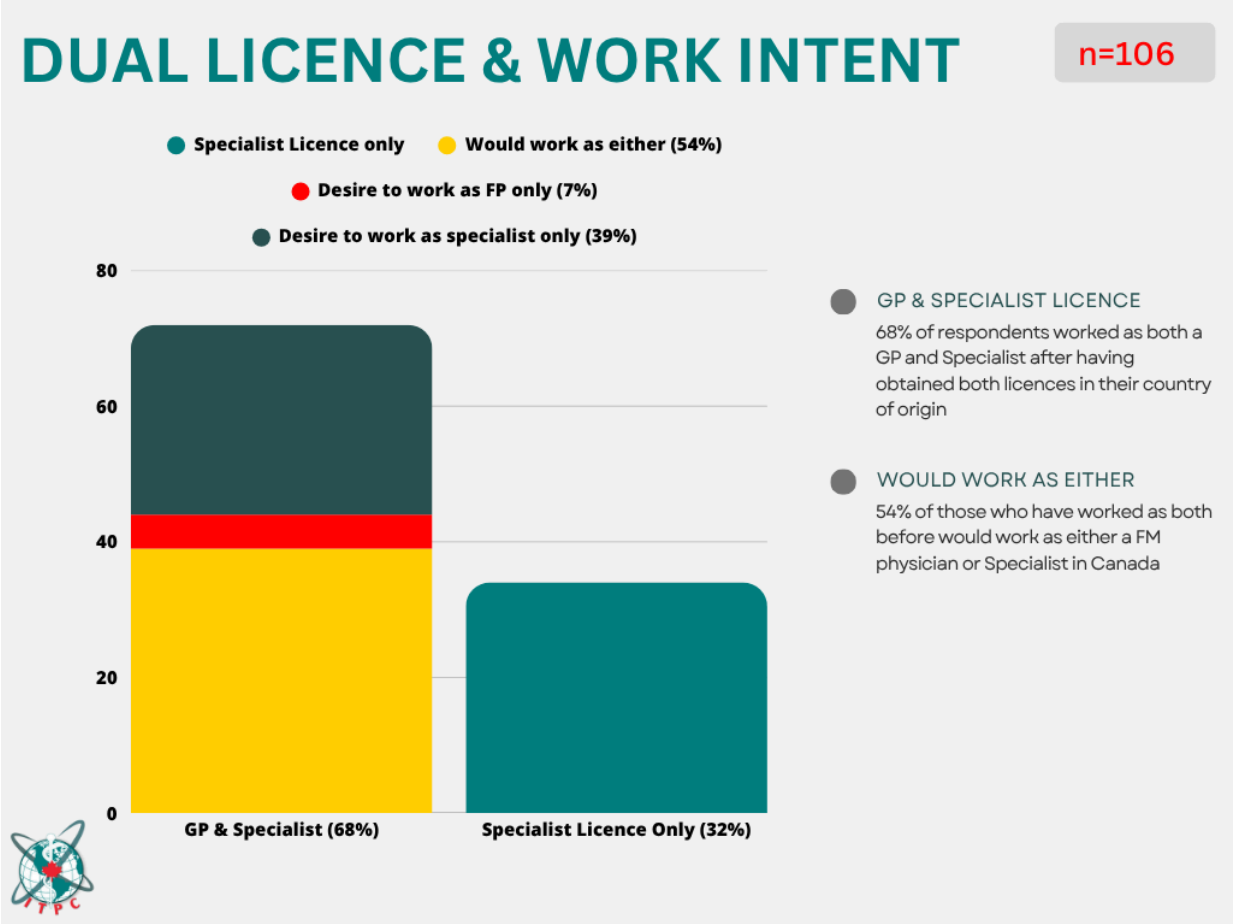

Figure 6. *Dual Licence and Work Intent in Canada (n=106)*

There is significant potential in integrating specialists who possess not only specialized knowledge but also experience as GPs into the Canadian healthcare system. This can be helpful in rural areas where both family physicians and specialists, such as psychiatrists, pediatricians, emergency medicine specialists and anesthetists, are in high demand (80). This holds great potential to minimize referral time, provide comprehensive care, efficiently utilize resources, and ensure continuity of care.

Barriers Faced by ITP Specialists in Canada

"Going forward, I notice that many of the provinces are opening, and I'm expecting that some openings will come and it will open for me. And I'm not the person who has ditched my dream. I'm pursuing my dream." BT, Physical Medicine and Rehabilitation specialist trained in India.

The journey of ITP specialists in Canada is often filled with barriers, from difficulties in navigating and accessing licensure pathways to financial burden, discrimination and frustration. Improving the integration of specialist internationally trained physicians will not only benefit health outcomes and address health workforce staffing issues but also address the underutilisation of ITP skills in Canada and lead to commensurate employment as every Canadian resident and citizen deserves.

Canada extends hospitable immigration policies for those with medical degrees and even enforces specific quotas for healthcare professionals, but when immigrant ITPs arrive in Canada, they face several barriers to entering the healthcare workforce (81). In 2022, only 67% of immigrant ITPs worked in a healthcare position, with just 28% of them working as physicians and 13% as clinical or laboratory medicine specialists (82). The underutilisation of these professionals' skills in Canada is part of the global phenomenon of "brain waste" (83,84)."Brain waste" and "brain drain" are both problematic occurrences.

"Brain waste" refers to the situation where individuals with higher education and skills are unable to utilize their talents and qualifications in their jobs. This often occurs when skilled immigrants work in jobs that don't match their level of expertise due to various barriers such as licensing issues, language proficiency, or discrimination. "Brain drain", on the other hand, is the phenomenon where highly educated and skilled people leave their own country to live and work in another country, usually for a better life (85). This can lead to a shortage of skilled professionals in the origin country. Maximizing the utilisation of the diverse and talented pool of ITPs already established in Canada is essential to mitigate both brain drain and brain waste (86).

General Barriers

Inequity and Discrimination

ITPs had strong feelings of discrimination and inequity with regards to, country of medical training, age, inequities in fees, cultural discrimination and more. There was a strong sense that they were not accepted as Canadians and that differences were being seen negatively as opposed to an important part of globalisation and diversity in the Canadian population. It is important that immigrants who are often in a powerless position, are empowered to believe that they belong (87). Feelings of belonging go beyond legal status and many ITPs feel that the system is not one that welcomes immigrant doctors.

"Yes, [there is discrimination against my country of medical training] and there is age discrimination. Once they figure out that you are like me, I graduated …in 1997, I would mention it in my CV, oh 1997…so this is an old man, almost 50. this is what the doctor who recruited me said to me, "be careful, there's a hidden discrimination problem, age-related, once they figure out that you are above 50, no one will hire you." EAA, Anesthesiologist trained in Algeria

"it's where you were born, where you studied; you get discriminated against by that. Even though most likely the books that you use over here in Canada or in the US, that's the same books that we use in Asia. But we're no good, we're not at par with Canadian standards. And yeah, that's discrimination….Yeah, this is 2024, what we learn is like, you know, global, whatever experience you have that like, you know, people should not be, I'm so sorry to say that, but people should not be so narrow-minded. We have to open ourselves to change already, and change means that we have to see others as our equal. So that's how I feel as being part of the visible minority over here in Canada." MLB, Emergency Medicine specialist trained in the Philippines

"Yes, I did [experience discrimination]. I did, you know, some phone calls, because I had to call them on the phone several times, you know. Somebody actually said, are you a doctor from Nigeria? You know, the way she pronounced it, but I just very calmly said, yes, from Nigeria. And so, you don't have any license anywhere else?" CN Occupational medicine specialist trained in Nigeria

"You have an accent. Even though you can speak two languages, national languages. But still,... you have an accent, you are an international medical graduate. This is an immigration nation. So acceptance and strong sense of cultural humility, all of us, we should have it. Correct? We should not say, oh, we should speak all Canadian accent. This is not correct." EAA, Anesthesiologist trained in Algeria

"They categorize non-approved jurisdiction and approved jurisdiction. Non-approved jurisdiction, we have to pay $7,000, for approved, only $3,500." EAA, Anesthesiologist trained in Algeria

"my specialty is it's kind of a dead end here in canada so yeah. So I decided that either I want to stay in Canada or I want to be a paediatric surgeon. I had to choose." SS,Paediatric Surgeon trained in Brazil

Navigation, Misinformation, and Inefficiencies

In general, there is a lack of transparency regarding all the aspects of licensure, and navigating Canadian license procedures can be tricky and often results in misleading information (86,88). Many official websites, such as CPSO, CaRMS and MCC, have historically lacked clear

information on licensure pathways in Canada, leaving ITPs to rely on word of mouth (89). This is slowly changing within the past few years. Fragmentation and a lack of coordination amongst health stakeholders also place a burden of redundancy and inefficiencies on the ITP. Also, although medical degrees are highly valuable during the immigration process, immigrant bodies such as consulates and embassies provide little information for newcomers on career pathways or the reality of what it takes to become licenced (90). This limited access to clear information and system disconnectedness creates additional burdens for ITPs (91).

"I had to discover the obstacles as I met them, so I was quite… so I think it affected the duration of my documentation. Because if I had all the information on hand, I would have had my documentation. I would have probably gotten everything within three months. So it made it longer. And because some of the things they have to do source verification and they have to contact the licensing or certifying body or the educational bodies." CN, Occupational Medicine Specialist trained in Nigeria/UK.

"There's not enough information online for, like you really have to search a lot and it's mostly other people telling you than actually from official websites." FL, Infectious disease specialist trained in Brazil.

"CPSO said they wouldn't use MCC documentation, they wanted documentation sent directly to them. I said, The CPSO is on the MCC sharing portal. Why can't I just share? They said no. So I had to do everything I did with PhysiciansApply account directly with CPSO. So it was multiple costs, unnecessary, longer time." CN, Occupational Medicine Specialist trained in Nigeria/UK.

"But the problem is that I don't understand the process very well…. I don't know. I'm lost. I'm telling you I'm lost…. there are nights where I couldn't sleep. And all just thinking, what should I do to start practicing?…..let's say you contact the college or anyone what they do oh they send you a link in your email from the college oh you can find all the information there [on the website], yeah but the information is really confusing". PY, Cardiologist trained in Lebanon/France.

Financial Burden

It is also important to consider the financial challenges ITPs face while navigating the route to practice medicine in Canada. Many ITPs spent over $10,000 trying to match into a Canadian residency program and do so while relying on entry-level non-medical jobs within the health and wellness sector, such as care aides, unit clerks, or clinic receptionists (92,93)(90),(92,93). Reports of ITP specialists, such as cardiologists and internists, working as cleaners or in construction fields are also not uncommon (94). On top of the wasted skills and knowledge, this also leads to feelings of isolation, frustration, and loss of identity as ITPs try to assimilate into a new country and culture (86,95). These experiences contribute to adverse mental health outcomes, described as "depressed and distressed" (86). In a survey by AIMGA that used

standardized scales, the majority (83.3%) of ITPs pursuing licensure reported high-stress levels, while over one-third (37%) had moderate to severe depression scores (95).

"So another thing was the cost. When you're not working, I'm not working back home, I'm not working in Canada. So, and these are very expensive exams, fees for licensing. And the process of getting the documents submitted, so you have to spend some money to process them to get to CPSO." CN, Occupational Medicine Specialists trained in Nigeria.

"Yeah, so one [barrier] was I said financial because of childcare, that was expensive. Because we don't have any avenue for a job like there's nothing else I can do. I'm only trained, I've only done medicine. So even the jobs that I could apply for would be minimum wage, which is not enough to cover daycare, honestly, you know. So financial definitely, I would say, and you don't get any subsidies. I told them that I am studying, but because it's a licensing exam, they don't consider it as they say, no, it has to be university or a full-time course. We don't consider licensing exams. So that was, you know, a challenge even to attend the exams are very expensive. So to attend the exams, to get the resources for the exams, definitely financial, I would say." CD, Psychiatrist trained in India

"Financial is a big thing because we have our savings in the other currency and coming here I literally spent all my savings in just the exams and that's why I did everything quickly because I knew once I would live here I would spend on things and so I just kept all my savings only and only for exams but it was a big barrier. I had to like at the end of it in fact I had to borrow some money from the family because it is very expensive." NN OBGYN trained in India

Recency of Practice

In most licensure pathways, recency of practice is a requirement. However, ITPs from war-torn or politically unstable regions face a significant challenge — returning to their home country to keep the recency of practice is either unsafe or entirely impossible. Additionally, once someone has made Canada their home, they should not be required to leave in order to access their profession.

"I am Palestinian-Canadian. I cannot go to Palestine. I cannot go to practice medicine again. I need minimum three to five years. Oh, you are out of practice. Go back to your home country, practice medicine, and submit your paper. I don't have a country. And you push me to be out of practice because you ask me to pass all my exams. So this is another barrier, and this is a discriminatory barrier. And go back to your home country. They are not treating me as a Canadian." EAA, Anesthesiologist trained in Algeria.

"For people who cannot or it is not safe for them, for any reason, to get back to their country, there could be an evaluation program. You have to prove that you are qualified to practice in Canada. I would see it as an opportunity to explore Canadian practice." AE, Dermatologist trained in Iran.

"I did look into the associate physician track in BC. Their latest assessment of my file was that I didn't have the recency of practice." ELD, Radiologist trained in China/Singapore

Access to Documents, Redundancies and Inefficiencies

Without access to documents or institutions that can verify their credentials (96), some ITPs are left in limbo, unable to progress through Canadian licensure pathways. ITPs are also sometimes made to submit the same documents to multiple institutions at different times.

"I see a lot of doctors who are quite senior and they say 'I've had this much experience, but I'm not getting into the field because the institute cannot give the documents - they are being bombarded'. There are many doctors from Ukraine and Palestine that are saying 'It's not our fault that the documents cannot come through'". GS, Psychiatrist trained in India.

"It affected me - the duration of my documentation. CPSO said they wouldn't use MCC documentation, they wanted the documentation sent directly to them. So it was multiple costs, unnecessary, longer time". CN, Occupational Medicine Specialists trained in Nigeria.

"they asked for almost like 37 documents to be done. I got all the documents like from Saudi Arabia, from Egypt and police check from the States. And then after that, all the papers were completed, they said, oh, we are not giving you a license because you need to get a job offer first. " RE, Ophthalmologist trained in Egypt

Barriers within RCPSC Pathways

Approved Jurisdictions and Programs

1) Accreditation Process Rigidity

"if the Royal College was more open to actually comparing curriculum for curriculum. Why wouldn't you look at the curriculum of somebody who has documented history of training with them and look at what's missing? Without that threat of, okay, I'm going to take your $5,000 from you, but I'm still going to tell you no because of this. Would you not just accept the assessment fee, look at what is deficient and work with that person to get them the remedies that they need? ELD, Radiologist trained in China

There are several steps that jurisdictions must go through to be granted accreditation status by the RCPSC (97). It is important to mention that these consist of a lengthy process involving several on-site visits for accreditation of the institution followed by similar steps for accreditation of specific programs. A considerable barrier is having the institution's structures and specific residents' support being compared to the Canadian reality. Because of some countries' lower

socioeconomic status, many jurisdictions would not meet the Canadian standard, though this does not necessarily reflect the quality of training or competency of the trained professionals.

In Canada, postgraduate training is assessed not only by years of training but also by competency in medical education, professionalism, and behavior — key components of accreditation. Historically, physicians typically came from English-speaking countries such as Ireland and the UK, which facilitated credentials and training assessments according to Canadian standards (98). While many countries use competency-based learning, their frameworks vary: Canada follows the CanMEDS Roles, the USA uses ACGME, and the UK applies the Good Medical Practice framework (99),(100,101). Australia and India have models somewhat similar to CanMEDS, whereas countries like Pakistan and Brazil use broader domains focused on expected achievements and competencies (102–104). Relying solely on written competencies from a medical residency curriculum may prevent Canadians from accessing skilled ITP specialists simply because they trained under different assessment systems.

2) Mismatch between Approved Jurisdictions and Programs, and Immigration Source Countries

"...they have some people they call approved jurisdiction. But I think they could also extend their approved jurisdictions as well too. Some other places because in Nigeria the training is very detailed, it's very comprehensive really." E, Ophthalmologist trained in Nigeria

Another important aspect to consider is that the Jurisdiction Approved Training pathway only includes eight countries and none of which are the countries where most ITPs in our survey trained, such as India, Bangladesh, Nigeria, Syria, and the Philippines (14). According to our survey, this pathway is inaccessible for most ITPs, as only four out of 106 (3.7%) completed training in one of the approved jurisdictions.

Additionally, not all medical specialties and subspecialties receive approval in each jurisdiction. The acceptance of training from these approved jurisdictions is contingent upon completion after a designated year. For example, training completed with The Royal College of Radiologists (United Kingdom - UK) is acknowledged if completed after 1975, while training completed with The Royal College of Pathologists (UK) is from 1996 onwards (14).

Practice Eligibility Route

1) Transparency and Information

The process to complete the practice eligibility route is not one that ITPs find transparent. Additionally, due to a lack of curated assistance to help ITPs through the process and no networking strong hold, ITPs often are unable to navigate the PER process

"I would say (my biggest barrier is) information. I haven't really met anybody who has done either PER or PRA in Ophthalmology. I'm not really sure how to proceed, you know, which way to go." E, Ophthalmologist trained in Nigeria.

2) Rigid, Duration-based Educational Assessment

"My biggest barrier is that they don't consider any type of practice or they force you to go back to get recent in your practice. Because for me, exams, you study for them and you are already out of practice. And the Royal College program in my country is four years and here is five years. AE dermatologist trained in Iran

"There is a practice eligibility rule in the Royal College that I will try to apply, and they have a way to do training year by year. But there are a lot of barriers, because for example, in Urology, my training was four years, but the training here is five years. MS Urologist trained in Colombia

One of the barriers for the PER process is the length of postgraduate training. In fact, one of PER's criteria is to have "time in training substantially equivalent to Royal College training standards" (105). In Canada, specialties such as Emergency Medicine, General Surgery, and Psychiatry last five years of training, while Pediatrics and Internal Medicine are usually four years (12). In comparison, in India, the country where most of our survey respondents trained, General Surgery training takes five years, but Psychiatry takes only three years (106),(107),(108). Further details on the common length of training in the various countries across regions where ITPs were trained and in Canada can be seen in **Table 3**.

Table 3. *Length of training requirements (in years) by specialty and country*

	Canada[1]	**India**[2]	**Nigeria**[3]	**Syria**[4]	**Iran**[5]	**Philippines**[6]	**Brazil**[7]	**Caribbean (UWI)**[8]
Anesthesia	5	3	5	4	4	3	3	3
General Surgery	5	5	5	5	4	5	5	5
Obstetrics and Gynecology	5	4-5	5	5	4	4	3	5
Internal Medicine	3-4	3	2	5	4	3	3	3
Psychiatry	5	3	5	4	4	3	3	3
Emergency Medicine	5	2	2	4	3	4	3	4
Pediatrics	4	3	5	4	4	3	3	3

Sources: [1] (7); [2] (106),(107),(108); [3] (109); [4] (110); [5] (111); [6] (112); [7] (113) ; [8] (114)

3) No Facilitated Supervisory and Employment Arrangements

"just doing fellowship one year, two years, and you have someone supporting you in the system, and the system will open. So in this department, there is more than 50% of [ITPs] coming here, fellowship, and they ended having a job full anesthesiologist, staff anesthesiologist with their restrictive work permit. The same year they came, and this is still continuing, restrictive work permit as a fellow and pick up a job. And I am here seven years. I presented myself, they know me, they work with me. Oh, we are sorry, we cannot help you. Even though I got an eligibility letter from the Royal College of Physicians and Surgeons of Canada… " GS, orthopaedic surgeon trained in India

"Even though I got a provisional license, I got a defined eligibility for the defined license from the Nova Scotia, I got a provisional license from New Brunswick, as well as from the PEI also. But I haven't got any job so far in those provinces. So even though once I have applied for a job in Nova Scotia, but they have turned my application down because they are saying that they are more eligible candidate than me, kind of that. So they haven't selected me for that. And after that, nothing more than that. And now I'm in Manitoba, and I have applied for the license here. And still I'm waiting for that. There's quite a hurdles are there in this also, in this provinces also. The job is there, but there is no unified kind of system, umbrella system in that for a job. And the thing is that I don't know how, where to approach, how to do the things, the problems I'm facing." GS, orthopaedic surgeon trained in India

"they said, oh, we are not giving you a license because you need to get a job offer first. [An employer] said we can like hire you as a refractive surgeon there. The College of Nova Scotia, they said no, this is not accepted because, you need to get a job either through Health Nova Scotia or through the university. It has to be a government job, not a private clinic job. Okay. So, yeah. It was, you know, it was hectic because I spent almost like the whole summer, almost four months preparing these documents and it was not obvious that the job has to be in a government section. You know, like because all over like since 2022 till now there are no government jobs there for ophthalmologists." RE, Ophthalmologist trained in Egypt

An important barrier that ITPs must overcome, as part of the PER criteria, is the requirement for time in practice in Canada. After their credentials are verified and they are deemed eligible for the RCPSC examination, ITPs must complete two years of continuous medical practice in Canada. However, with postgraduate medical residency training or fellowships in Canada being accepted only for up to one year and in only certain circumstances for this requirement, candidates are forced to acquire a license through provincial MRAs and secure a job position (13,14). This creates a significant challenge for ITPs, who not only face a lack of transparency and clarity on licensing processes, but also struggle with securing employment in a system where access to opportunities may depend on personal connections or guidance. These barriers ultimately limit the full utilisation of ITPs' skills, delaying their integration into the healthcare system and further exacerbating workforce shortages in areas of high need.

The costs associated with the PER route pose a significant barrier for some ITPs. The PER assessment fee alone is $4,845, separate from exam fees, which can total up to $10,635 (115). These expenses can be particularly challenging for ITPs from countries with depreciated currencies, as well as for newcomers who rely on minimum-wage jobs and have low or limited credit scores. Implementing financial support initiatives for ITPs in these situations could expand access to this pathway, increasing the pool of skilled candidates.

Subspecialty Certification

"I don't think there is any possibility of of me becoming a pediatric surgeon here in Canada. At least I was told so by the staff at [institution], unless I redo all my residency. So I'm not willing to spend the next seven years trying to achieve that. Surgery is very, very… I think they they don't like letting people in easily so I don't think they announce those things yeah, that getting into that is difficult, they have limited or even at some places no spots at all. I even, I know some people that are really well connected pediatric surgeons from abroad and they couldn't find a place to work. So I don't think that's a pathway that it's open for me." SS Paediatric Surgeon from Brazil

1) Transparency and Information

Employers and ITPs alike are often confused as to the process whereby subspecialists can be licenced and employed. ITPs experience profound uncertainty as to whether they will succeed at the assessment of their training and therefore are at risk of losing the large sum of fees.

"Even the provider from the HR department has sent me an email where she told me that she doesn't know what to tell someone with my profile, my experience and everything. People like me are the people that are really needed here in Canada. She contacted, herself, the Royal College and the [regulatory college]. Later she told me that she doesn't know why they are making this thing complex to me." PY, Internal Medicine and Cardiologist trained in Lebanon

"To get the letter of eligibility, you need an assessment application that takes between eight to 12 months. And nothing is guaranteed. And I checked the fees of that application. It's in the thousands. And they don't refund anything from the Royal College to you. So imagine." PY, Internal Medicine and Cardiologist trained in Lebanon

2) Misalignment with international routes to subspecialties

Similar to PER, the rigidity of assessment of curriculum poses a problem for ITPs. Some programs that are subspecialties in Canada are core specialties elsewhere. The route to subspecialisation is variable globally. The length of training is also variable. These are all items that do not measure competence and are all out of the ITPs control. By using these parameters, Canada is preventing skilled subspecialists from entering the system.

"So the training there, it's two years in general surgery and three years in pediatric surgery. Pediatric surgery is a specialty over there. We have residency. Unlikely here that pediatric surgery, it's a, It's a, I don't know how they call it, but it's not a residency. It's a fellowship. It's a two-year fellowship. So in general, they are called here general surgeons. It's different over there. It's a core residency, but with this, I need two years in, in general surgery." SS Paediatric Surgeon from Brazil

"I tried the Royal College of Physicians and Surgeons of Canada route. I found out that for me, to be able to practice occupational medicine in Canada, I have to have a residency in internal medicine using that pathway [which I don't have]." CN, Occupational Medicine specialist trained in Nigeria/UK

3) Limited access to fellowships for SEAP route

Accessing fellowships in Canada to proceed through the SEAP route is extremely difficult. Fellowships that are approved for SEAP are few. For subspecialists to be able to pursue this route to affiliation and eventually licensure, more fellowship spots are necessary.

For pediatric surgery, it's almost impossible. For instance, [institution] has [this fellowship] and [ITPs], they don't have the same status and completing this fellowship won't give you any certification to work here in Canada. Now, I'm a fellow [but] research fellow so it's not really training in surgery. SS Paediatric Surgeon from Brazil

Barriers within Practice Ready Assessment

1) Eligibility Issues

"I even got a job offer, but I was not eligible. I could work under supervision because there are two pediatricians that were willing to supervise my job. But I couldn't obtain a license, I couldn't work there." MV, Pediatrician trained in Argentina.

"Give us the opportunity to practice under their supervision. We have the competency, we have the expertise." EAA, Anesthesiologist trained in Algeria.

Many Provincial PRA Specialty programs still require the applicant to gain Royal College Eligibility in their primary specialty to be able participate in the program or to be able to retain a provincial license afterwards (35). Alternatively, some use similar "length of training" requirements, based on the royal College's framework, to determine eligibility (116). Given the barriers mentioned in the PER route above, this is a limiting factor to the incorporation of specialist ITPs into the health workforce.

2) Cumbersome Processes

"Probably I can, let's say, practice as specialist. I know that there is those PRA pathways, but it's very complicated to go there in order to study your application. I contacted the colleges and everything. They told me each application needs to be studied at least for like one year or something like that so I found like it's a lot of paperwork…" PY, Cardiologist trained in Lebanon

The procedure for completing the PRA pathway for specialists can be intricate and often involves multiple organizations. For instance, in Alberta, ITPs must initially register with the College of Physicians & Surgeons of Alberta (CPSA), followed by obtaining sponsorship from Alberta Health Services. Subsequently, they undergo Preliminary Clinical Assessment (PCA) and Supervised Practice Assessment (SPA), both contingent on the availability of PCA and SPA. The CPSA locates an assessor or supervisor for the ITP and schedules the assessment dates. This process can be time-consuming and may take a while due to the scheduling constraints of PCA and SPA (34).

The PRA specialist pathway in Manitoba is further complex as candidates cannot directly apply to the assessment program. Instead, a screening panel selects candidates from a list of candidates who have applied for provisional membership. It all starts with the Regional Health Authorities in Manitoba submitting vacant specialist positions to the Manitoba Healthcare Providers Network (MB Health). Next, the candidates who applied for provisional membership with the College of Physicians and Surgeons of Manitoba (CPSM) must apply for the positions available on MB Health. This network then creates a shortlist of applicants for the screening panel, and once the panel identifies a suitable candidate, the University of Manitoba IMG Program office arranges the assessment (35).

3) No PRA specialist program or limited spots and capacity

"*I looked at the PRA in Ontario and spoke with the medical recruiters, but unfortunately it was open only for a family doctor. I would apply if I had the possibility, if it was open for my specialty. I wouldn't mind working as an emergency doctor anywhere in the north of Ontario close to where I live. I didn't have this opportunity.*" MK, Emergency Medicine specialist trained in Brazil.

Some provinces like Ontario have no PRA program at all. Others are limited by availability of assessment spots, assessors and supervisors. To be eligible for PRA in Nova Scotia, individuals must first receive approval from the provincial practice-ready body. However, this body can only accommodate a limited number of applicants at a time, depending on the availability of assessors and supervisors (117).

4) Lack of facilitation for assessment and supervision; dependent on employer

"I emailed the College in Saskatchewan (asking) if I could be a partner in the clinic and practice there because they have a route called the pre-PRA which is pre-license assessment.

It's a pathway for [ITPs] that you get, you know, assessed for three months of practice, and according to the records, they can give you a defined license for a year, and if you pass this year uneventful, you can get a defined license for another year, and then you get a full license after that. But the problem is that it needs supervision from the board of doctors there. So, I tried to arrange a meeting with these doctors. I met three of them, and the head of the department just told me - what's the benefit that we're gonna get as doctors from supervising you?" RE, Ophthalmologist trained in Egypt.

Many PRA programs put the burden of finding a supervisor or place of employment on the ITP. This creates a difficult situation in which an immigrant who is already not familiar with the country has to find a way to convince doctors who are strangers to them to facilitate supervision. This is a dangerous power dynamic that does not facilitate the incorporation of ITPs into the health workforce.

5) Recency of practice (as in general barriers)

"My biggest barrier is that they don't consider any type of practice or they force you to go back to get recency in your practice." AE, Dermatologist trained in Iran.

The recency of practice requirements in numerous PRA pathways can be difficult criteria for many ITPs to overcome. In Quebec, eligible candidates need 12 months of practice in the relevant medical specialty within the last two years (33). Similarly, in Nova Scotia, candidates must show recency of practice, with at least six months of experience within the three years before starting the clinical field assessment (94,117). This can be challenging for immigrant ITPs en route to citizenship as they are required to have continuous 1095 days in Canada within the last five years for their application (118). It also presents a considerable hurdle for those who cannot return to their home country because they cannot leave their source of income or families in Canada to pursue professional endeavours, and the ones who cannot return due to fear of persecution or civil unrest in their country of origin (17,19,86).

Barriers within Residency Pathways

"It's hard to find a doctor who accepts [ITPs] for observerships. That's one of the barriers. But the main one is the amount of money that we have to spend." FL, Pathologist trained in India.

"Most of the time, the physicians didn't even reply to my letters, my applications. Anything. And sometimes I was considered overqualified. It's very frustrating because we usually have a lot of experience and even if it is not in my area of expertise, if I was willing to work anywhere, even as a clerk or PSW (personal support worker)." MK, Emergency Medicine Physician trained in Brazil.

"[For CaRMS], it's the recency in graduation. That's the biggest criteria, that's the most important criteria for CARMS. I've seen people like we had group of studies, we knew each other's scores, people like with just the pass score, just like few scores above the pass and only because they are recent in their graduation. Nothing else, no research, nothing. They don't have your resume, they don't have even practice after the graduation. They're just out of the board, came to Canada, wrote the exam and that's it. I've seen 100% of them get there. So to me, it sounded like being ageist." NP, Paediatrician trained in Colombia

"So I think one of the things that made a difference was I was in a smaller city, I tried to make as many connections as possible. So I tried to work with doctors, to speak with people, to make Canadian friends, networking, because, you know, I am from 2014, so I have almost years of graduation. And I knew this is something bad for me, for the process, I know. And this is something I cannot change. So what can I do? What can I change in this? You know, my red flags, what of my red flags I can change and try to modify my situation? Because I knew, okay, I am an old grad, this is not going to change. And I know some places were not going to call me for an interview, for example, because of that. I know, but what can I change? I can make connections and I can get good letters and be seen. That's the maximum I can do. But I think it's the most useful tip for the process. Try to make connections. Because unfortunately, we see this. We see that when you match, you have any type of connections. You have an experience at the university or experience in the health care system. Or this is something that happens, so we need to dance according to the music. So that's it." MK, Emergency Medicine Specialist trained in Brazil

1) Limited residency positions
2) Preference for Canadian-ness
3) Lack of transparent feedback
4) No recognition of previous clinical experience

ITPs' participation in postgraduate training in Canada is limited for various reasons, including expectations of Canadian healthcare experience and limited residency positions. ITPs are often told they need "Canadian experience", but they are not adequately provided opportunities to fill such a gap (86). As a result, many take on volunteer roles or low-wage jobs within the healthcare system (85,119,120).

One way for ITPs to gain Canadian experience is through observerships. Currently, only a few provinces offer a regulated hands-on clinical observership opportunity: AB, BC, and NS (121–123). In AB, the observership license is restricted to residents of the province, which limits the options for ITPs living in other parts of Canada (121–123).

Another pathway to gain Canadian work experience is through regulated Clinical Assistant/Associate Physician positions, available in AB, BC, MB, NB, NL, and NS. However, these positions have only been recently implemented in some provinces, are highly competitive and not widely available (124–129).

A high number of applicants and limited seats lead to minimal chances to match into residency positions for ITPs compared to CMGs; and only recently unfilled positions from the first round of CaRMS have become available to both CMGs and ITPs during the second iteration of the cycle (38).

ITPs have fewer opportunities to match into their specialty of choice, as some residency programs only allocate positions for CMGs. Surgical specialties are particularly scarce for ITPs. In 2023, 70 General Surgery positions were designated for CMGs, while only four were available through the IMG stream and 15 through the regular stream. After the match, ITPs secured only three positions at the University of Toronto, whereas CMGs filled 84 General Surgery spots. Similar trends are observed in other surgical specialties, such as Ophthalmology, Orthopedic Surgery, Plastic Surgery, and Obstetrics and Gynecology, where ITPs are allocated fewer than 10 positions despite a total of 1,569 applicants. These results highlight a clear marginalization of ITPs compared to CMGs (130,131).

Another known frustration factor for ITPs in the postgraduate route is the lack of clear selection criteria and feedback from rejecting medical residency programs (91). Program descriptions do not provide a scoring system for candidate files, except for the Family Medicine program in Manitoba, where a clear scoring breakdown is provided (41). Program faculties also do not provide the rationale for participants' rejections, which leads to multiple unsuccessful attempts at CaRMS cycles, ultimately leading to frustration and regret (132).

Most residency programs prioritize recent medical graduates. In the first iteration of the 2024 CaRMS cycle, 75% of current-year ITP graduates matched, compared to only 33% of those who graduated in previous years (133). In our survey, over 85% of the respondents had three or more years of postgraduate training, which may put them at a disadvantage when applying to residency programs. There is anecdotal evidence of programs mentioning filtering candidates based on years since medical school graduation, with filters of three, five or 10 years (134,135). Despite being built on principles of fairness and equity, CaRMS fails to address the systemic barriers that ITPs face, resulting in disproportionately low match rates and limited residency positions available to them (136).

Competency of ITPs is a common concern, but research done in the USA shows that ITPs are as competent as their counterparts, and patients treated by ITPs have lower mortality rates than those treated by US graduates, despite ITPs treating more chronic conditions and patients of lower socioeconomic status (137). Another analysis from Ontario demonstrated no difference in mortality outcomes between patients treated by ITPs and CMGs (138). Numerous studies have underscored comparable or even superior knowledge and health outcomes among ITPs (138–140).

Solutions to Incorporate ITP Specialists in the Healthcare System

"There are a lot of immigrants with experience and knowledge that they [Immigration, Refugees and Citizenship Canada] are bringing to Canada. Canada is supposed to be a little more open to accept those immigrants and the knowledge they bring in.

When I worked in South Africa, they had a limited registration. That means you are going to be evaluated continuously by your head of department, but at least they give you the opportunity to work.

If Canada truly wants to incorporate the knowledge of the immigrants, somebody has to change the current rules." JS, Anesthesiologist trained in Cuba.

Several solutions exist to improve the integration of ITP specialists into Canada's healthcare system, from simplifying documentation requirements and delivering clear information on official websites to expanding available residency positions and providing suitable alternative pathways.

Our recommendations are divided into two sections: one suggests solutions for general barriers encountered by ITPs navigating the system, and the other offers guidance on improvements in specific pathways as well as proposals for additional pathways

Addressing General Barriers

Mitigating Inequity and Discrimination

Mandate anti-bias, anti-racism and anti-discrimination training and discussions

A conscious effort must be made to increase the level of awareness of these issues and importance must be placed on actions that can help to mitigate them. Mandatory annual CPD in anti-bias, anti-racism and anti-discrimination training for practicing physicians particularly those that will be in a position of power over an ITP, such as supervisors, assessors and preceptors should be instituted. Similar training should also be mandated for personnel involved in ITP-related policy and program decision-making roles.

Discussions about power dynamics as it relates to the ITP population should receive the same level of attention as clinical discussions at conferences, grand rounds and similar events. Anonymised case examples that help to demonstrate the issue, impact, and preferred actions towards mitigation should be presented and discussed.

Solving Navigation and Misinformation Issues

Establish a unified immigration and licensure official taskforce

This taskforce should include federal and provincial immigration representatives, national certification bodies, national and provincial medical regulatory bodies to create a central table to align information distribution, operational processes, and capitalize on efficiencies.

Specialist ITPs have considerable difficulty accessing precise and reliable information about licensure pathways in Canada. Provincial Colleges, RCPSC, MCC, and CaRMS websites should have more straightforward frameworks for the paths they offer to ITPs. Many ITPs migrate under a points-based system, under which their medical professional degree gains them points. No transparent information is given that this will not ensure a smooth transition into healthcare nor information on the depth of the disconnect that exists between immigration recruitment and actual professional opportunities.

Forming a unified task force between licensing, certifying and immigration stakeholders, to implement a “one-stop” online resource for ITPs could significantly reduce the challenges associated with navigating Canada’s licensure pathways and the disconnected immigration system. A task force will also help federal and provincial immigration organisations to understand the realities of the licensure system and challenges therein. Through this taskforce a focus should be put on ITPs that are already in Canada, instead of continuing to recruit ITPs to suffer under the current system.

Providing clear, accessible information about the licensing process would help prevent misunderstandings. Detailing the required documentation, certification, and examinations would allow ITPs to make informed decisions and better prepare for licensure. With accurate guidance on the necessary steps, including completing exams before arrival, ITPs can enhance their readiness and improve their chances of integrating into clinical practice in Canada more quickly.

Improving Access to Documents, Redundancies, and Inefficiencies

Streamline documents and alternatives across and within immigration and licensure

The aforementioned unified task force of licensing, immigration and certifying officials, should have as a focus, streamlining document requirements and acceptable alternatives and taking advantage of efficiencies, by accepting documentation already approved by another taskforce organisation. This taskforce will allow for alignment of information distribution, operational processes, and capitalising on efficiencies.

Relieving Financial Burden

Establish or expand financial bursaries and non-repayable grants

The journey to licensure in Canada can be costly and financially inaccessible for several ITPs, especially those relying on low-wage salaries to support themselves and their families. To ease this transition, a financial aid program could help cover the costs of applications, exams and certification. Expanding access to loans and non-repayable financial aid, similar to programs in Manitoba (141,142) and Nova Scotia (143), would support skilled ITPs without compromising their recency of practice while also benefiting the Canadian economy. Better interim employment, such as a Laddered Associate Physician Program as discussed below, would better enable financial security for ITPs while on the licensure journey.

Supporting Recency of Practice

Laddered Associate Physician Program

The limitations of staying current in practice while in Canada have a significant impact on the ITP. This barrier cuts across every pathway to licensure. A licenced Associate Physician program that ladders into a pathway to independent licensure would ensure that ITPs keep practice currency, while contributing immediately to the health workforce, and then provide sustained care as an independent practitioner. A program like this solves many issues at once, including: recency of practice, access to healthcare, financial instability, sustainability and retention of health workforce.

Addressing Pathway-Specific Barriers

Improve RCPSC Pathways

Approved Jurisdictions Proposed Solutions

1) **Expand Approved Jurisdictions in line with immigration patterns**

The current approved jurisdictions, including residency program approval and the ACGME route, are restricted to ITPs trained in few programs in a few countries, which do not account for the current migration patterns to Canada and the jurisdictions where most of our survey respondents have trained (14,53). Expanding the approved jurisdictions in line with immigration patterns must be a priority. Thousands of ITPs remain unlicenced in Canada, despite being Canadian Citizens/Permanent Residents.

2) **Simplify, collaborate on, and increase transparency of, the accreditation process to be able to approve more jurisdictions**

Implementing a less time-consuming and complex accreditation process for international institutions and programs can make this pathway more accessible for ITPs and preserve their recency of practice.

In the context of healthcare globalisation, we must embrace international collaboration opportunities and implement a competency framework that considers the varying contexts of international health education systems. A collaborative approach to creating accreditation processes that are accessible and achievable for international institutions should be undertaken. ITP- serving organisations in Canada, such as ITPC, can assist with information sharing and networking, eventually leading to partnerships with international medical associations and institutions. Joint knowledge exchange initiatives and research projects can also help improve accreditation processes so that they are more accessible to the countries that most immigrants come from and therefore more jurisdictions can be approved. Reciprocity with international institutions would be beneficial to moving this collaborative approach forward.

A transparent online resource with clear and more extensive information regarding the standards and accreditation process should be considered. This will enable institutions to do work on their own towards achieving accreditation before even engaging with the RCPSC.

Practice Eligibility Route, SEAP, PER-SEAP Proposed Solutions

1) **Implement flexibility in training assessment and allow ITPs to demonstrate further competence via the RCPSC examination**

International training programs vary widely in structure. This is not a measure of competence or quality. Flexibility must be ingrained into the training assessment process in order for qualified ITP specialists and subspecialists to be able to access non-approved jurisdiction routes to certification or affiliation. Whether a jurisdiction classifies a specialty as core while another classifies it as a subspecialty, should not prevent an ITP from being eligible to sit the Royal College exam that would further prove their competence. Many specialist ITPs have extensive independent clinical practice, and focusing primarily on the scope of residency training can overlook their significant expertise and contributions. By considering a combination of specialty training, independent practice experience as both specialist and generalist, along with successful completion of country specific board exams, more physicians could access RCPSC routes.

In lieu of mapping directly onto a rigid assessment of curricula, consider adjuncts to this approach through which ITPs can prove that they have the competence either longitudinally in training or through practice experience, as well as their success on their country of training board examinations. Adjuncts can include, local board exam review and success, attestations, clinical case logbooks that detail the specified exposure, modular assessments that focus specifically on the competency in question or a combination of these.

Through curriculum assessment and adjuncts, ITP specialists should be granted eligibility to sit the RCPSC exams which will further prove their competency.

2) **Implement supplementary options for fulfilling required training**

If curriculum assessment and adjuncts are not sufficient for the ITP to be granted eligibility, options for supplementary training should be made available. Rotations within residency programs or fellowship programs that can help fulfill the required training/competencies should be made available to ITPs. This would only be necessary if curriculum assessment plus the proposed adjuncts fail to be sufficient to grant eligibility.

This will enable qualified specialists to easily and efficiently meet the remaining requirements and become eligible to sit the appropriate RCPSC examination.

3) **Collaborate with PGME offices to facilitate fellowship connections**

There are insufficient fellowship opportunities that align with the RCPSC requirements to be able to access the SEAP pathway. Qualified ITP subspecialists can be easily incorporated into the healthcare workforce, if fellowship opportunities can be facilitated. The RCPSC and PGME Directors should collaborate to create a new process whereby ITPs can apply for eligibility to access SEAP except for having completed the fellowship requirement. Once eligible the RCPSC and PGME offices should facilitate the processes of matching these ITP specialists into a fellowship program to complete the requirement.

A system that involves the RCPSC, PGME offices and ITPs can lead to an efficient and effective path toward affiliation status for ITPs that they can use toward licensure.

4) **Standardise the policies that incorporate RCPSC certification/affiliation with the licensure process across MRAs**

How different routes to Royal College certification translate into licensure eligibility creates inequity across Canada, with some routes to certification allowing for a restricted/defined/provisional licence and practice before Royal College examination (eg. Nova Scotia), while others only allow for a restricted/defined/provisional licence after examination (eg. Ontario). Practice experience in Canada is helpful to ITPs intending to sit RCPSC examinations. SEAP is accepted for an independent licence in some provinces (eg. Manitoba) but only provisional in others (eg. Saskatchewan). This adds to the complexity and frustration of an already intensive journey for the ITP.

All MRAs should align on standardised policies for the path from certification/affiliation to licensure for the various RCPSC routes.

5) **Facilitate supervisory job opportunities**

MRAs, Health ministries and agencies and the RCPSC should collaborate to facilitate controlled matching to job opportunities to allow for the fulfillment of time in practice required to complete RCPSC routes to certification. ITPs face significant challenges in finding job opportunities on a licence that requires them to be supervised. It is difficult for them to find a physician willing to supervise them and when they do they face exploitation. Immigrants do not have a well developed network and therefore are at a disadvantage when trying to navigate job

opportunities. There is a power imbalance between an immigrant physician asking for supervision from a licenced independent physician in Canada with whom they have no prior professional relationship. A facilitated approach would also allow for the involvement of licenced ITPs who would likely be more willing to be supervisors.

Once an ITP has reached the stage of fulfilling the time in practice requirement, this process should be collaboratively facilitated to support the completion of this requirement and moving Canada one step closer to an independently licenced specialist.

6) **Provide equitable preparation for the RCPSC examinations**

CMGs are prepared over their entire residency to sit RCPSC examinations. ITPs do not have access to mentors, and examination preparation sessions and resources in the way that CMGs do. Exam preparation resources that suit the ITP context, and go beyond just a structure breakdown and sample questions are imperative. ITPs need the opportunity to engage with experts on how the examination works, and an opportunity to access structured mentorship and study sessions. Recently the University of Calgary has started something similar (though expensive) for the CFPC examination (144).

Additionally, exploring the possibility of offering certification examinations for ITPs in locations outside of Canada will allow candidates to take exams without needing to travel to Canada and risk losing recency of practice.

Improve Practice Ready Assessment

Implement a programmatic approach to Specialist PRA across Canada

The existence and availability of PRA for specialists is quite obscure. Not all specialties are available in all provinces and when, which specialties will be available remains ambiguous. Unlike the PRA for Family Medicine which is actively promoted in provinces like NS, ON, SK and more, specialist PRA does not have this visibility. Even after exploring MRA websites and registration policies, the process to be taken for specialist PRA remains quite unclear to many ITPs. Family medicine PRA is run in a programmatic manner, while specialist PRA is not. ITPs are required to seek out their own sponsorship or are only able to apply if a job posting is available in their specialty. This is difficult for a newcomer to navigate.

For family medicine PRA, there is an intake period or rolling intake followed by orientation, facilitated assessment placement and post-clinical assessment placements in areas of need. Establishing a PRA program for specialists in all provinces and territories, right alongside FM PRA, can facilitate the integration of ITPs into the workforce and enable faster allocation of physicians to areas affected by specialist shortages.

A specialist PRA program that can consistently assess ITPs in any RCPSC speciality should be implemented across Canada.

Improve flexibility in eligibility criteria for PRA programs across Canada

Specialist PRA requirements expect ITPs to meet the RCPSC certification standards. This means that if ITPs do not meet the standards, they are automatically excluded from both PER and PRA. PRA programs should allow ITPs to showcase their competence in a RCPSC accepted specialty without having to meet rigid structural requirements of curricula that they can no longer change. PRAs should assess clinical competency that ITPs have gained over years of clinical experience. ITPs who have trained in a specialty, passed their specialty exams and have gained a licence to practice in their country of licensure should be allowed access to a licence through a PRA.

All ITPs with specialty training that is approved in their country of licensure should be eligible to be assessed via PRA to obtain a license to practice in Canada.

Improve Residency Access and Selection Processes

Expand and Open all Spots

There is a significant disparity between the number of specialty residency positions available to ITPs compared to CMGs. Expanding the number of positions ITPs can apply for would enhance diversity in training and the workforce while ensuring the selection of the most qualified candidates. This could be achieved by increasing residency positions and implementing competitive residency spots across Canada, as seen in SK and QC (130,131) and, more recently, in BC (69).

All residency spots should be open to ITPs entering the CaRMS match as they are permanent residents or Canadian citizens just like CMGs are and should be afforded equal opportunities to uphold their human rights.

Revise selection criteria to capture ITP strengths

Current criteria for residency selection are not built to capture ITP strengths. Criteria focus on medical school rotations, grades and electives. Most ITPs have several years of practice and accomplishments while practicing in the field. Criteria continue to focus on “canadian-ness” and gaining experience in the clinical space in Canada. However, regulated clinical assistant roles are few relative to the number of ITPs and do not exist in every province. Therefore, ITPs take on many roles in the health sector while trying to secure a pathway to licensure. These roles capture all of the CanMEDS roles but yet do not get weighted favourably in residency selection criteria. Similar can be said about the additional education that ITPs undertake to stay productive and relevant. ITPC has previously published ideas for revision of residency selection criteria (145).

Residency selection criteria should be revised to consider the context of the immigrant ITP already here in Canada and ITPs with years of clinical experience and not only that of a new medical graduate.

Provide clear and transparent feedback

Efforts should be taken to provide transparent feedback, so that ITPs can gain some insight into which areas they should try to improve for the next CaRMS cycle.

Monitor and Expand New innovations

Raise successful provincial innovations to the national level
Provincial initiatives, eg. PACE, PEI-McMaster Collaborative, pathways from defined/provisional/restricted licences to full licensure, should be monitored and once successful, raised to the national level to be adapted and enacted across Canada for equity. A focus should be on helping ITPs that are already here and not only on the traditional “approved jurisdictions”.

Create Additional Pathways

Clinical Assistant/Associate Physician Ladder to Full Licensure

Implement a regulated associate physician role that ladders into an independent licensure pathway across Canada

“I had a CA position in Cardiology in Halifax. I focused on Cardiology for a reason so that I shifted my focus from purely obstetrical and surgical branches to a medical one. And it's a very known busy service here in Halifax. Many people join and then they leave in one or two months because it's very, very busy. So I worked here for a year and now I applied in this (CaRMS) cycle for the first time and I got into Family Medicine.” NN commented on switching her OBGYN training to Family Medicine in a comfortable manner due to the support of CA position.

It is important to note that currently, practicing with an AP license does not lead to full licensure and may or may not count toward recency requirements in other pathways. Currently, regulated CA/AP positions are available in AB, BC, MB, NB, NL, and NS. Within this framework, APs can work in both acute and community primary care settings under the supervision of attending physicians, not being authorized to practice independently. In regulated positions, APs have clearly defined duties and responsibilities and receive competitive compensation (124–129). In Ontario, many specialist ITPs work as CAs in medical offices. However, as this is not a licensed position, there is considerable variation in terms of training requirements, scope of practice, and salary. Without regulation, ITPs often occupy various precarious roles in physician offices to gain local experience. This may lead to unseen discrimination and exploitation in the workplace (146).

As discussed in our previous report, regulated CA and AP roles hold significant potential for strengthening the healthcare workforce and improving access to care in regions with critical medical needs (17,19,20).

ITPs should be able to start in the health system with a regulated CA/AP role to maintain/regain currency of practice and then be transitioned in a facilitated and structured manner into a pathway to independent licensure such as residency, PRA. This can even facilitate any additional clinical exposure required for certification pathways.

A nationwide laddered regulated CA/AP program will allow for:

1. Regaining/Maintaining Recency of Practice

Recency of practice is a major barrier that affects ITPs significantly throughout all pathways to licensure. It is important to solve the recency of practice barrier for ITPs that are already in Canada, to be in line with Health Canada's Ethical framework for the recruitment and retention of internationally educated health professionals in Canada (147).

2. Short term workforce that transitions into long term health workforce, promoting sustainability

Licensed CAs also assist with managing patient workload and help alleviate physician burnout, potentially resulting in enhanced patient satisfaction and allowing for expansion of the patient roster (148). ITPs that work as CA/APs in underserved and rural communities would be more likely to settle there and work as a fully licenced physician, once they are provided a ladder into a full licensure pathway.

CA/AP positions are currently restricted to only six provinces (124–129), expanding these positions across Canada can help alleviate the human resource deficits and improve access to care, especially if used strategically, targeting specialty fields of need. This report's findings show that 68% of ITP specialists also have experience working as a general practitioner, and therefore would be an invaluable asset to underserved and rural communities as generalists.

Additionally, regulated CA and AP positions could serve as a supplemental training for specialists ITPs who do not yet meet the requirements for the PER route. This approach would prevent internationally trained specialists from having to repeat full residency training in their original specialty, allowing more residency positions to be allocated to those without postgraduate training.

3. Invaluable orientation to the Canadian Healthcare system

Entering a new healthcare system requires orientation for proper integration. Residency programs and PRA programs have all recognised the importance of orientation to set ITPs up for success. CA/AP programs that ladder into licensure represent an excellent opportunity for orientation directly on the ground, while supporting patient care.

Summary of Recommendations

Table 4. Summary of recommendations

Objective	Solution	Highlights
Solutions to General Barriers		
Mitigating Inequity & Discrimination	**Mandate anti-bias, anti-racism and anti-discrimination training and discussions**	Training and mandatory grand rounds style case discussions on issues of inequity and discrimination
Solving Navigation and Misinformation Issues	**Establish a unified immigration and licensure official taskforce**	A central table to align information distribution, operational processes, and capitalise on efficiencies.
Improving Access to Documents, Redundancies, and Inefficiencies	**Streamline documents and alternatives across and within immigration and licensure**	A central table to streamline document requirements and acceptable alternatives including accepting documentation already approved by another taskforce organisation.
Relieving Financial	**Establish or expand financial bursaries and non-repayable grants**	A financial aid program could help cover the costs of applications, exams and certification.
Supporting Recency of Practice	**Laddered Associate Physician Program**	A program that ladders into a pathway to independent licensure would help ITPs keep practice currency, contribute immediately to the health workforce, and then provide sustained care as an independent practitioner.
Solutions to Pathway-Specific Barriers		
Improve RCPSC Pathways: Approved Jurisdictions	**Expand Approved Jurisdictions in line with immigration patterns**	Align approved jurisdictions with immigration patterns and the countries that ITP specialists that are already here come from.

	Simplify, collaborate on, and increase transparency of, the accreditation process to be able to approve more jurisdictions	A collaborative approach to creating accreditation processes that are accessible and achievable for international institutions.
Improve RCPSC Pathways: PER, SEAP, PER-SEAP	**Implement flexibility in training assessment and allow ITPs to demonstrate further competence via the RCPSC examination**	In lieu of mapping directly onto a rigid assessment of curricula, ITPs can prove competence longitudinally in training, through practice experience, and their success on their country of training board examinations. Adjuncts can include, local board exam review and success, attestations, clinical case logbooks that detail the specified exposure, modular assessments that focus specifically on the competency in question or a combination of these. Through curriculum assessment and adjuncts, ITP specialists should be granted eligibility to sit the RCPSC exams which will further prove their competency.
	Implement supplementary options for fulfilling required training	If curriculum assessment and adjuncts are not sufficient for the ITP to be granted eligibility, options for supplementary training should be made available. Rotations within residency programs or fellowship programs that can help fulfill the required training/competencies should be made available to ITPs.
	Collaborate with PGME offices to facilitate fellowship connections	The RCPSC and PGME Directors should collaborate to create a new process whereby ITPs can

		apply for eligibility to access SEAP except for having completed the fellowship requirement. Once eligible the RCPSC and PGME offices should facilitate the processes of matching these ITP specialists into a fellowship program to complete the requirement.
	Standardise the policies that incorporate RCPSC certification/affiliation with the licensure process across MRAs	All MRAs should align on standardised policies for the path from certification/affiliation to licensure for the various RCPSC routes.
	Facilitate supervisory job opportunities	Once an ITP has reached the stage of fulfilling the time in practice requirement, this process should be collaboratively facilitated to support the completion of this requirement and moving Canada one step closer to an independently licenced specialist.
	Provide equitable preparation for the RCPSC examinations	ITPs do not have access to mentors, and examination preparation sessions and resources in the way that CMGs do. ITPs need the opportunity to engage with experts on how the examination works, and an opportunity to access structured mentorship and study sessions.
Improve PRA Pathways	**Implement a programmatic approach to Specialist PRA across Canada**	A specialist PRA program that can consistently assess ITPs in any RCPSC speciality should be implemented across Canada. For family medicine PRA, there is an intake period or rolling intake

		followed by orientation, facilitated assessment placement and post-clinical assessment placements in areas of need. Establish a PRA program for specialists in all provinces and territories, that runs in a programmatic manner like the FM PRA.
	Improve flexibility in eligibility criteria for PRA programs across Canada	All ITPs with specialty training that is approved in their country of licensure should be eligible to be assessed via PRA to obtain a license to practice in Canada.
Improve Residency Access and Selection Processes	**Expand and Open all Spots**	All residency spots should be increased and opened to ITPs entering the CaRMS match as they are permanent residents or Canadian citizens just like CMGs are and should be afforded equal opportunities to uphold their human rights.
	Revise selection criteria to capture ITP strengths	ITPC has previously published ideas for revision of residency selection criteria (146). Residency selection criteria should be revised to consider the context of the immigrant ITP already here in Canada and ITPs with years of clinical experience and not only that of a new medical graduate.
	Provide clear and transparent feedback	Efforts should be taken to provide transparent feedback, so that ITPs can gain some insight into which areas they should try to improve for the next CaRMS cycle.

Monitor and Expand New innovations	**Raise successful provincial innovations to the national level**	Successful provincial initiatives should be raised to the national level to be adapted and enacted across Canada
Create Additional Pathways	**Implement a regulated associate physician role that ladders into an independent licensure pathway across Canada**	ITPs should be able to start in the health system with a regulated CA/AP role to maintain/regain currency of practice and then be transitioned in a facilitated and structured manner into a pathway to independent licensure such as residency, PRA. This can even facilitate any additional clinical exposure required for certification pathways.

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Appendices

Appendix A. Requirements for the Approved Jurisdiction Route.

1	Medical specialty training must have been completed outside Canada and the United States in one of the RCPS approved jurisdictions.
2	Time in training should be substantially equivalent to the Royal College specialty training requirements/training experiences in the given speciality.
3	Document signed by the Program Director/Supervisor attesting to ITP periods of training is required.
4	Letter of attestation of competence from ITP's Program Director/Supervisor which specifically outlines their competencies around the seven roles of the CanMEDS framework is required.
5	Medical training documents need to be source verified by PhysiciansApply (Medical Council of Canada).
6	Candidate must successfully complete the speciality assessment conducted by RCPSC.

Source: (14)

Appendix B. Requirements for Practice Eligibility Route (PER).

1	Medical training should be completed in the discipline for which the candidate is applying
2	Medical training should have been completed outside of Canada, the United States and Royal College of Physicians and Surgeons Canada (RCPSC) approved jurisdictions.
3	Time in training should be substantially equivalent to RCPSC training standards.
4	Medical training documents need to be source verified by Physicians Apply.
5	Candidate must be recognized as a specialist in their jurisdiction of training.
6	Candidate must provide satisfactory evidence of completion of all postgraduate medical education training requirements of the jurisdiction in which training occurred.
7	Following approval by the Credentials Unit of a successful initial credentials review, the candidate must successfully complete the speciality examination(s) conducted by RCPSC.
8	Candidate must have at least five (5) years of total practice.
9	Candidate must have at least two (2) years of continuous medical practice in Canada

Sources: (14,105)

Appendix C. Requirements for PRA Specialist Programs by Province.

Province	MCCQE1	NAC	Length of postgraduate training	Experience	Currency of Practice
Alberta	Yes	No	At least 48 months of discipline-specific postgraduate specialty training. Both the training and certification process must be substantively equivalent to that required by RCPSC	Same as postgraduate training	12 months within the last three years.
Nova Scotia	Yes	Yes	Postgraduate training that is substantially equivalent to Canadian training and has been satisfactorily completed	Minimum of 3 years of independent practice in the discipline	At least 450 hours within the last 3 years
Manitoba	No	No	Hold the qualification to independently practice medicine in the specialty field from the jurisdiction where the physician trained and completed an acceptable postgraduate clinical training program in their intended field of practice	Same as postgraduate training	None
Quebec	Yes	No	Completed postgraduate training that is roughly equivalent to that required in Quebec	Same as postgraduate training	12 months during the last two years

Sources: (33–36)

Appendix D. Survey Questionnaire.

1	Are you considered a specialist in your country of training (any specialty other than general practice, e.g. General Practitioner, Family Physician, House Officer)?
2	What is your area of specialty (any specialty other than general practice, e.g. General Practitioner, Family Physician, House Officer)?
3	What is the specialist title that you held?
4	What is your country of training?
5	To be considered a specialist in your country of training, you need to: (choose all that apply) a) Just complete a residency/postgraduate training b) Complete a medical residency/postgraduate training and pass a board exam c) Work in the field for a minimum of years and then pass a board exam d) Other (please specify)
6	If you had residency/postgraduate training in your specialty area: NOT counting medical school AND broad-based INTERNSHIP, how many years of formal training did you complete before being considered a specialist?
7	If you didn't have residency/postgraduate training in your area of specialty: NOT counting medical school AND broad-based internship, how many years of working experience did you have to complete before being considered a specialist?
8	How many years of experience do you have AFTER being considered a specialist in your country? (NOT counting experience as a House Officer or General Practitioner)
9	To your knowledge, is there currently a residency/postgraduate training program in your specialty in your country? If so, please provide information about it (e.g. length of the residency program, need for board exams, need for prior experience etc.)
10	Did you work as a General Practitioner ALONG with your specialty practice (not prior)? If so, would you prefer to practice as a GP, specialist or both/either in Canada?

Appendix E. Interview Guide.

Specialists Interview guide

Thank you for coming to this interview. Everything you share with us today is confidential. This means that your identity will be protected and we won't share your name or any other identifying information in our report. Your interview will be recorded. Only the project team will have access to the recording and we will only use it for transcription. It will be deleted afterwards. Your participation is completely voluntary. You can choose to share as much or as little as you want, and skip any questions, or stop the interview at any time. Do you have any questions before we begin?

Q1 Please tell us a bit about yourself

- What is your speciality in your country of origin?
- How many years of training do you have?
- How many years of independent experience do you have?
- Did you practice as a GP along with or before becoming a specialist?

Q2 Please tell us about your journey in Canada so far:

- Attempts for CaRMS (including interviews)
- Applications for alternative specialty pathways
- Job sector currently working in (healthcare vs business vs hospitality, etc)

Q3 What was your experience so far navigating pathways to clinical practice in Canada?

- How easy or difficult was it for you to navigate specialty pathways in Canada?
- Are you aware of alternative pathways such as RCPSC Approved Jurisdiction route, Practice Eligibility Route (PER), Subspecialty Examination Affiliate Program (SEAP), Practice-Ready Assessment (PRA) for specialists?
- If so, have you applied for any of these? Why or why not?

Q4 What barriers did you face in order to enter your specialty in Canada? What has been the biggest barrier in your accreditation towards becoming a medical specialist in Canada ?

- Barriers to alternative certification pathways (RCPSC Approved Jurisdiction route, Practice Eligibility Route (PER), Subspecialty Examination Affiliate Program (SEAP), Practice-Ready Assessment (PRA) for specialists
- Barriers to CaRMS
- Financial barriers
- Recency of practice
- Canadian clinical experience

Q5 How aware are you of the opportunities to gain Canadian experience (i.e. CA, observerships, Supervised Short Duration Practice License (SSDO) in Ontario etc.)

- Canadian experience attained, where and duration

- Was this experience regulated (meaning you had to get a license from a College of Physicians and Surgeons in your province) or unregulated
- Was this paid or unpaid?

Q6 Have you worked as a Clinical Assistant or Associate Physician?

- Was this a regulated position (meaning you had to get a license from a College of Physicians and Surgeons in your province)?
- What has been your experience working as a CA?
- Do you work in the same specialty as your training?
- What is your level of job satisfaction?
- Are you planning to continue working as a CA or explore other opportunities?

Q7 Have you considered switching to another specialty (such as Family Medicine)?

- Why have you considered this?
- If switched, what is your level of job satisfaction?

Q8 How open do you think Canadian colleges are in recognizing foreign training?

- How do you think this can be improved?

Q9 Did you ever feel discriminated against because of the country of medical training?

Q10 At this point, what are your plans going forward?

Is there anything else that you would like to mention?