

**Written Submission regarding Petition e-3378: Establishing a reciprocal agreement allowing physicians (and potentially other healthcare workers) to work across provincial boundaries**

**By:** Dr. Paul Mackey

MBBS, DRANZCOG, DA, CCFP (FPA), FCFP, FRACGP, FRRMS

FP Anesthetist

UBC Clinical Assistant Professor

UBC Family Practice Residency Program

**Recommendation #1:** That the federal government urgently develop a National Physician Licensure Strategy.

**Recommendation #2:** That the federal government pass legislation implementing a reciprocal agreement across all provinces and territories allowing physicians

(and potentially other healthcare workers) to work across provincial and territorial borders

**Recommendation #3:** that the federal government emulate the Australian approach by developing a legislative framework that enables national licensure of physicians.

## Background

The COVID 19 Pandemic has highlighted Canada's urgent need for a National Physician Licencing Strategy. The current licencing framework hinders the free movement of medical workforce across the country and has negatively impacted the healthcare of Canadians, including First Nations.

I will share my personal story and situation with the committee to illustrate how a single physician licensing system or reciprocal agreement across the entire country could make a significant difference for the delivery of healthcare in rural and remote regions of the country.

I am a rural family physician with enhanced skills in anesthesia, emergency medicine and obstetrics. I am a Clinical Associate Professor in the UBC Family Practice Residency Program and was responsible for developing the rural Fort St John Family Practice Residency Site and serving as its Site Director for 7 years. I practiced as a rural generalist, with the aforementioned enhanced skills, in the community of Fort St John, British Columbia (BC) for 20 years. I have now relocated to Kamloops, BC, and provide rural locum services, predominantly in BC but also in the Northwest Territories (NWT) and Manitoba (MN).

During the pandemic, I was able to provide locum services at very short notice in communities such as Williams Lake, Fort St John, and Inuvik when local family practice anesthesiologists were required to isolate because of SARS-CoV-2 exposures.

On June 12, 2021, I received an urgent locum request via the Society of Rural Medicine RuralMed Email list to provide coverage in the remote community of Moose Factory, ON, to help with the SARS-CoV-2 outbreak occurring there. Despite being licenced in BC, MB, and the NWT, and having worked in the (relatively) nearby community of Thompson, MB, I was unable to offer assistance due to the barrier of provincial physician licencing.

I have faced similar barriers attempting to provide assistance in remote Newfoundland. I have just received a request to cover in Prince Edward Island but, again, provincial licencing precludes offering my broad skill set.

The provincial licencing Colleges falsely maintain that they allow free movement of physicians across borders. My personal experience attests to this misrepresentation. When answering the urgent call to Inuvik, I had to make a full licence application to the NWT, which required attempting to obtain Certificates of Professional Conduct from my original degree city of Melbourne, Australia (which was in the middle of its historic lockdown), and from the United Kingdom, where I completed my anesthesia training over 25 years ago. This seems excessively cumbersome, not to mention expensive, in light of my having been a practitioner in good standing in BC for 25 years. The challenges inherent in this process meant my arrival in Inuvik was delayed.

In early 2020, I had started the process to obtain a license in Newfoundland in preparation for providing summer relief for a colleague in St Anthony. After taking 5 months to meander through the process, my application stalled as the community was no longer able to provide me a job offer due to pandemic restrictions. Thus, I currently have no licence in Newfoundland and in order to provide locum services there, I would have to start the licence application over.

My experience doing a work sabbatical in Australia in 2017 was a stark contrast. I applied to convert my non-practicing registration with Australian Health Practitioner Regulatory Agency (AHPRA) to active and

was licenced to practice. I provided solo General Practitioner services in a coastal Tasmanian community, which otherwise would have had none, for 3 months before relocating to work as an Emergency Department Physician and Anesthetist in the underserved community of Katherine, Northern Territory. This seamless transition from the most southern state to the Northern Territory required no change in my licensure with AHPRA.

During the pandemic, there have been numerous occasions when regions of Canada have required urgent assistance with medical workforce needs. Provincial licencing restrictions have impeded the free movement of physicians and thus limited the assistance that could be offered and negatively impacted patient care. This is even more evident in our rural and remote communities. These communities are already under-served, and physicians require a broad yet specific skill set to be able to competently work in these communities. The barrier of provincial licensing limits the pool of physicians who can respond to urgent needs.

Having a national approach to physician licensing, or at the least a system of reciprocal agreements, would address many of these barriers. It would open up the ability to recruit locums and regular physicians from population centres that are geographically much closer but in a different province. There are many underserved rural communities across Canada for which this would be a significant improvement, including in the territories. Many of the communities affected by this have significant Indigenous populations, exacerbating systemic inequities.

I am aware of Petition e-3378 and would support that approach, if it is legally feasible in Canada. I am extremely aware healthcare falls under section 91(11) of the British North America Act and as a result is a provincial jurisdiction. Another Westminster style constitutional monarchy has figured out how to solve these issues: Australia moved to a single physician license in 2010, under the umbrella of a single national regulatory body AHPRA.

Surveys from the Canadian Medical Association show that 91% of physicians in Canada would support a move to a single licensing body. No reasonable person would object to a national solution affecting the availability and safety of patient care. Notably, the requirements to obtain full licensure are the same in every province. The pandemic has highlighted the need for Canada to have a mobile healthcare work force. Australia solved this issue for its licensed healthcare practitioners in 2010. It is long overdue for Canada to do the same.