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Canada guilty of medical poaching

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Byline: Carol Goar
Column: Carol Goar
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There's a brain drain we don't like to talk about in Canada.

We actively recruit doctors, nurses and other medical professionals from some of the world's poorest countries. We don't pay for their education. We know their people need them more than we do.

But we have a doctor shortage. More than 1.2 million Canadians can't find a family physician. We have one of the lowest doctor-to-patient ratios in the industrial world. With 2.1 physicians per 1,000 people, we rank behind Hungary, Greece, the Czech Republic and South Korea.

We have an aging population and a large wave of medical retirements coming. More than a third of our doctors are over 55.

So we put on moral blinders and hire health-care professionals from developing countries. But we can't ignore the consequences of our actions, says Tom McIntosh, who has just completed a study called The Ethical Recruitment of Internationally Educated Health Professionals.

We have a responsibility, as members of the global community, to balance our needs against those of peoples struggling with AIDS, malaria, tuberculosis, dysentery and high infant mortality.

McIntosh, a professor at the University of Regina, leads the health team of **Canadian Policy Research Networks**, a think-tank that aims to promote dialogue on difficult societal issues.

Foreign medical recruitment definitely falls into that class. It is a tangle of conflicting rights, interests and needs. No nation has unsnarled it, but several are doing better than Canada.

In 2004, the British government adopted a code of practices for international medical recruiting. In 2002, the Commonwealth put in place a set of guidelines (which Canada refused to endorse).

In 2001, the International Council of Nurses issued a groundbreaking position statement on ethical recruitment.

None of these models is perfect, McIntosh says. But they hold important lessons for Canada:

- They all reflect a consensus that it is inappropriate for wealthy countries to solve their undersupply problems by luring physicians from developing nations.

- They all recognize the right of medical professionals to practise where they choose, provided they are not breaking any laws or abrogating any commitments.

- They all try to differentiate between poaching foreign-trained doctors and providing the information they need to decide whether to relocate.

- And they all advance the principle that rich countries should make some attempt to compensate poor countries for the medical talent they take.

Canada would have to adapt its approach to our highly decentralized health-care system, McIntosh says.

Ottawa couldn't just sign one of the international codes of conduct, for instance, because the federal government doesn't have the authority to tell the provinces how to recruit health-care professionals.

A national code of conduct, while desirable, would require an extraordinary degree of intergovernmental co-operation in a field fraught with turf wars and funding battles.

The most promising option, he believes, would be for one or two of the provinces to take the lead.

Saskatchewan, which has the highest percentage of foreign-trained doctors in the country, is already developing a plan. The issue is also on the radar screen in the Atlantic provinces, which rely heavily on medical newcomers.

About a quarter of the doctors now working in Canada (23 per cent of general practitioners and 22 per cent of specialists) are foreign-trained. The proportion has not changed substantially since the 1960s.

What has changed is the source of our medical talent. The British Isles, which used to account for 60 per cent of incoming doctors, now provide 18 per cent. The new suppliers are South Africa, India, Egypt, Pakistan, Saudi Arabia and the Philippines.

McIntosh does not see any easy or obvious solution to the problem. Barring new medical immigrants wouldn't work. It would violate their right to determine their own future. Forbidding health authorities from seeking doctors overseas wouldn't work either. No government has the power to enforce such a ban.

The best we can do, he says, is to make a strenuous effort to become medically self-sufficient, help low-income countries train and keep doctors and develop the fairest and most transparent international recruiting practices that we can.

But first we have to confront the issue. Then, we have to start talking.

- Carol Goar is a nationally syndicated columnist. She can be reached at cgoar@ok.bc.ca.

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