HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

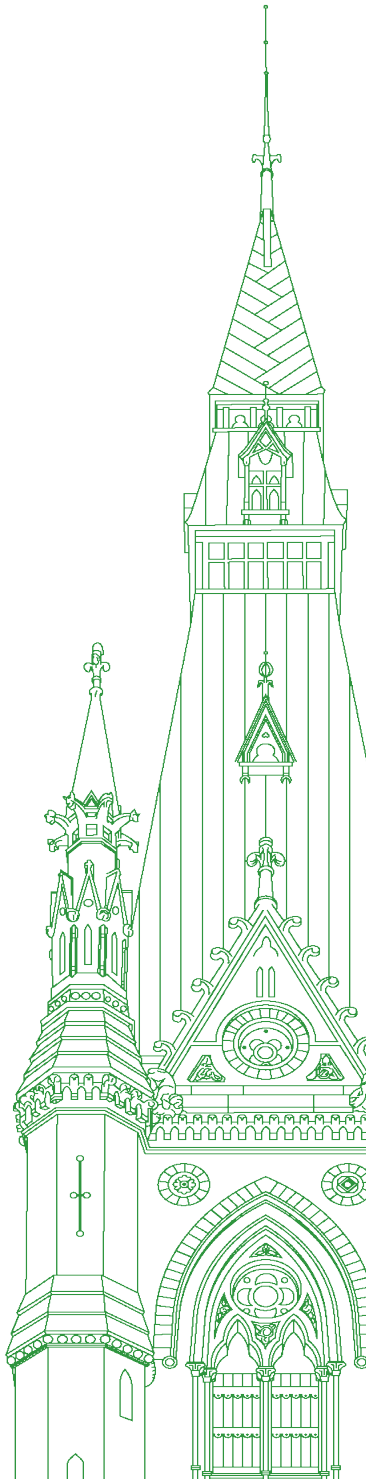
45th PARLIAMENT, 1st SESSION

Standing Committee on Health

EVIDENCE

NUMBER 011

Thursday, November 6, 2025



Chair: Hedy Fry

Standing Committee on Health

Thursday, November 6, 2025

● (1105)

[*English*]

The Vice-Chair (Dan Mazier (Riding Mountain, CPC)): Hello, everyone. I'd like to call this meeting to order.

Welcome to meeting number 11 of the House of Commons Standing Committee on Health. Today's meeting will be in a hybrid format, pursuant to the Standing Orders that we're all so familiar with.

Pursuant to the motion adopted on Tuesday, September 23, 2025, the committee shall resume its study of the impact of immigration policy on health care and barriers to integrating internationally trained professionals.

Before I welcome our witnesses, I do have some housekeeping items.

There was a motion circulated, on which I am seeking unanimous consent, for the digital binders for associate members on behalf of all parliamentarians. They do not have access to those digital binders right now. All the other committees have done that.

I'm just seeking unanimous consent for that motion. It was circulated weeks ago.

(Motion agreed to [*See Minutes of Proceedings*])

The Vice-Chair (Dan Mazier): We have UC. Very good. Thank you.

With that...yes?

Burton Bailey (Red Deer, CPC): I'd like to address an email that was circulated by a Liberal member before this meeting today.

The Vice-Chair (Dan Mazier): Did you want to speak, Mr. Bailey?

Burton Bailey: I do want to speak, Mr. Chair.

The Vice-Chair (Dan Mazier): Okay. Thank you.

Burton Bailey: I'd like to address an email that was circulated by a Liberal member before this meeting today implicating one of our witness organizations in some sort of conspiracy about the freedom of religion of Canadians.

I'd like to quote the email from the Liberal member from Winnipeg West:

> Just realized a potential trap the conservatives might spring with the Catholic organization. They describe themselves [as] having “Catholic Values”. The conservatives have been claiming that the Liberal Government has been planning to remove charitable status for religious organizations. It came up during the campaign and they are regularly submitting petitions about this.

I'd like to know what the member means by saying that Conservatives describe themselves as having Catholic values. What are Catholic values to the member? What is wrong about having Catholic values? I find it reprehensible that the Liberal member would use the term “Catholic values” in a negative way, especially considering one of our witnesses here today, a community organization that has been doing good work in providing programming, education and social integration of newcomers for over 40 years, as somehow part of a broader conspiracy.

We're here to gather perspectives from a variety of organizations and individuals about the impact of immigration on Canadian health care. Liberals are denigrating the freedom of religion of Canadians, which is just typical behaviour, proving once again the views of our society...value nothing and want to tear down our society and values.

The Vice-Chair (Dan Mazier): Thank you, Mr. Bailey. Was this just a statement?

Burton Bailey: Yes.

Doug Eyolfson (Winnipeg West, Lib.): Mr. Chair, may I respond?

The Vice-Chair (Dan Mazier): No. We're in the middle of a study.

Doug Eyolfson: Something has been said about what I sent. If he's been given the time to say that, I insist that I have the opportunity to respond to that.

The Vice-Chair (Dan Mazier): First of all, I gave him the floor. I did not give you the floor. I said we were moving forward with the study, so we're just going to move forward with the study—onward and upward.

Doug Eyolfson: Objection. I have a point of privilege, Mr. Chair.

The Vice-Chair (Dan Mazier): Yes.

Doug Eyolfson: You said we were on the study. You gave the other member the floor. I'm being accused of something, and I insist on having the opportunity to respond and clarify, because I believe my comments have been misrepresented. I insist on the opportunity to respond to that.

The Vice-Chair (Dan Mazier): Mr. Eyolfson, we have witnesses here from right across this country. We have committee members here. I'm sorry—

Doug Eyolfson: Then why did you give the floor to Mr. Bailey for this?

The Vice-Chair (Dan Mazier): Because he asked for it.

Doug Eyolfson: Yes, and I'm asking for it too.

The Vice-Chair (Dan Mazier): I didn't acknowledge you, though.

Doug Eyolfson: No.

The Vice-Chair (Dan Mazier): You just started speaking.

Doug Eyolfson: I asked for the floor. Mr. Bailey asked for the floor.

The Vice-Chair (Dan Mazier): If you want to take this up after the witnesses are done—

Marcus Powlowski (Thunder Bay—Rainy River, Lib.): On a point of privilege, I think he has a point. I mean, you did recognize one of the Conservatives who wasn't a witness. We should be accorded the same ability to have a say in this matter. Otherwise, it would seem like there's some bias on the part of the chair, which is supposed to be a non-biased position.

The Vice-Chair (Dan Mazier): Okay. As usual, Marcus, you've swayed me over.

Very good.

Doug Eyolfson: Thank you.

I would like to clarify—

The Vice-Chair (Dan Mazier): But please do not let this.... We have witnesses, and we have to get on with it.

Doug Eyolfson: I understand. I just insist on responding. I will be quick.

First of all, my apologies for sending it “reply all”. The reference I made was not to denigrate any Catholic values. The reason I brought this up was that there has been a statement.... No denigration on the part of the organization, but I have been hearing, in the House, several petitions brought forward by the Conservative Party regarding a claim that our party wants to remove charitable status for religious organizations, which is untrue and which is included in the text of that. That is why I brought this up.

There is no denigration of this organization. There is no denigration of people who follow the Catholic faith. There is simply asking members to prepare for this particular point being brought up and giving clarification to the point.

That's all I had to say.

Thank you, Mr. Chair.

The Vice-Chair (Dan Mazier): Thank you, and thank you for being brief.

Thank you to the witnesses for being part of the study today.

We have three parties in front of us. From the Canadian Physiotherapy Association, we have Krissy Bell. From World Education Services, we have Shamira Madhany. From Catholic Community Services of York Region, we have Dr. Ali Amiri and Dr. Antanina Hulko.

We will start with Krissy Bell.

You have five minutes for your opening remarks, after which the floor will be open to questions.

Krissy Bell (Chief Executive Officer, Canadian Physiotherapy Association): Thank you, Mr. Chair and members of the committee, for the opportunity to appear today on behalf of the Canadian Physiotherapy Association, which represents more than 30,000 credentialed physiotherapists.

Physiotherapists are first contact primary health care professionals. They are evidence-based, regulated practitioners who help Canadians recover from injury and illness, manage chronic conditions, and maintain mobility and independence. Our profession plays a key role in relieving pressure on the health care system, keeping people out of emergency rooms, shortening hospital stays and supporting faster recovery after surgery and faster return to work after injury. In the management and treatment of back pain, osteoarthritis and coronary heart disease alone, physiotherapy reduces the financial burden on the health care system by $232 million a year.

Over the last decade, the number of physiotherapists educated outside of Canada—what we call IEPTs—has grown steadily. In 2014, they made up about 14% of the workforce. Today, they account for nearly one in four, or 25%, of all practising physiotherapists in Canada. That's more than 7,600 individuals, and our numbers have been growing.

IEPTs are keeping physiotherapy services available and accessible to Canadians at a time of growing shortages. They help meet patient demand, particularly as the population ages and chronic conditions increase. They don't just fill jobs; they strengthen professional excellence.

Yet, despite this success, many internationally trained applicants still face long, complex and costly pathways to practice in Canada. It can take up to two years to become licensed, with fees approaching $2,000. That's just for the clinical assessment and does not consider bridging or language programs they may take to ensure their success.

As a partner, the CPA supports the ongoing work of CAPR, the Canadian Alliance of Physiotherapy Regulators. The alliance is making real progress by doubling exam sittings, digitizing credential assessment and launching a new pre-approved credentialing pathway to speed up recognition. However, system-level bottlenecks remain, and that's where federal leadership can make a real difference.

Supporting the integration of IEPTs through faster credential recognition bridging programs and targeted incentives will yield immediate and measurable results to both patients and the health care system.

On the domestic side, we have 15 accredited physiotherapy programs in Canada. We're very excited that we have one more in preaccreditation. In 2023, these programs offered 1,166 student seats. About 950 students graduate each year, while 1,800 new positions open annually. The number of graduating students entering the system is simply not able to keep pace with population growth or labour demand.

Competition for a spot in one of the country's master's programs is fierce. Some programs receive over 1,000 applicants for their 60 or 70 seats. This large applicant pool results in some Canadians leaving the country to pursue training abroad. By helping those Canadians return to practice in Canada, Canada can expand its workforce quickly and cost-effectively.

It takes at least six years to become a physiotherapist, including both undergraduate and graduate education. Students graduate with average debt loads of about $40,000. That debt discourages many from practising in rural and remote areas, where Canada faces persistent shortages.

We were pleased to see the Liberal government's commitment to expand the Canada student loan forgiveness program to include physiotherapists. I would strongly encourage the committee to ask for an update on the status of this program, which was supposed to come into force this month. Thousands of students are eagerly awaiting an update.

Over the next decade, 18,700 job openings are expected in physiotherapy, driven largely by growth in demand for services and an aging population.

What can the federal government do? In the short term, fund CAPR's efforts to streamline credential recognition; provide grants and bursaries for Canadians trained abroad to return home and practise here; fund bridging programs that accelerate licensure, using successful provincial models, such as B.C.'s internationally educated physiotherapist bursary program; and incentivize rural and remote practice, expanding student loan forgiveness and similar programs to include physiotherapists.

In the long term, increase training capacity in Canadian physiotherapy education programs and strengthen workforce data and mobility frameworks to allow physiotherapists to move more easily between the provinces and territories.

In short, physiotherapy represents one of Canada's most underutilized solutions to our health care challenges. By investing in training, recognition and integration, we can grow a resilient workforce, improve access to care and deliver better outcomes for Canadians at a lower cost.

● (1110)

Thank you again for the invitation to appear today. I'm excited to answer your questions.

The Vice-Chair (Dan Mazier): Well done. That was right down to the second. That's impressive.

World Education Services is next, with Shamira Madhany.

Shamira Madhany (Managing Director, Canada and Deputy Executive Director, World Education Services): Thank you, Chair and members of the committee.

My name is Shamira Madhany. I'm the deputy executive director and managing director of World Education Services, or WES for short.

On behalf of WES, I'm pleased to contribute to this important study on the impact of immigration policy on health care and the barriers preventing internationally educated health professionals from fully contributing to the Canadian health system.

WES is a not-for-profit social enterprise that has worked for over 50 years to support the educational, economic and social inclusion of immigrants, refugees and international students. Since 2013, we've been one of five organizations designated by IRCC to provide educational credential assessments for applicants under express entry, in support of the verification of international credentials. In health care, we work closely with system stakeholders and groups representing internationally trained professionals in medicine and nursing to address systemic barriers that prevent qualified immigrant professionals from obtaining licensure and working in their professions.

Chair and participants, health care systems across Canada are in crisis, facing a predicted shortage of over 117,000 nurses by 2030 and more than 20,000 family physicians by 2031. At the same time, thousands of internationally educated health professionals, or IEHPs, living in Canada are ready and qualified to help. Many are Canadian citizens or permanent residents. However, despite their qualifications, training and experience, almost half are not working in their professions.

The systemic barriers preventing IEHPs from becoming licensed to practise are well documented. Their underutilization carries profound economic and social costs. However, rather than focusing on the barriers, I would like to focus on the solutions.

Successful solutions that have a positive impact are being implemented across the country and across health care professions. However, these initiatives are unaligned and contribute to an increasingly fragmented patchwork of licensure processes, criteria and supports for IEHPs. Licensure outcomes therefore can depend on where a person pursues licensure.

The complexity of systems and stakeholders involved in this issue demands pan-Canadian, cross-departmental and multi-sector approaches. The effort to find and align solutions must be guided by federal leadership and involve collaboration across federal departments and between levels of government, as well as with regulatory bodies, health education systems, health care employers, organizations representing IEHPs themselves and non-government partners.

In order to achieve this, WES recommends that the federal government take a leadership role in developing a pan-Canadian strategy and a coordinating body. While provinces regulate professions, the federal government has a critical role to play in ensuring coherence, consistency and fairness across the country. The federal government should establish a permanent, cross-department, cross-jurisdictional mechanism to guide strategy, planning and alignment across immigration, health and labour portfolios.

This coordinating body would accomplish three key outcomes.

First, it would streamline and harmonize licensing pathways for IEHPs by developing national standards based on evidence and competencies.

Second, it would facilitate the establishment of federal frameworks to implement and expand proven best practices, including modernized registration processes, supervised clinical experience and assessment models, and career navigation supports tailored to specific occupations. It would also align immigration selection and licensing, ensuring that individuals invited through category-based selection in health occupations have viable pathways to licensure and practice in Canada.

Third, it would support advancing a comprehensive health workforce data strategy that includes information about IEHPs, enabling evidence-based health workforce planning, decision-making and evaluation.

Our written submission contains additional details, which I'd be happy to speak to during the question period.

● (1115)

In conclusion, the talent we need to solve many of our health care challenges is already in Canada and ready to contribute. The question is whether we can align our systems to recognize and mobilize it.

Thank you.

● (1120)

The Vice-Chair (Dan Mazier): Thank you.

Our last testimony will be from the Catholic Community Services of York Region.

I believe you're splitting your time. You have two and a half minutes each.

Ali Amiri (International Medical Doctor, Catholic Community Services of York Region): Yes, we are.

The Vice-Chair (Dan Mazier): Go ahead. Welcome.

Ali Amiri: Thank you.

Mr. Chair and honourable members, thank you for the opportunity to speak.

My name is Ali Amiri. I was born and raised in Iran. I ranked 12th out of 150,000 candidates on the Iranian national university entrance exam, trained as a physician and worked for over four years before completing a clinical Ph.D. in Europe. Eventually, I came to Canada as a post-doctoral fellow at the University Health Network, working in cancer research.

When I arrived, I faced a system that I didn't fully understand. The journey as an IMG is long, demanding and uncertain. Catholic Community Services of York Region, CCSYR, helped change that for me. In their free IMG support groups, I prepared for my exams. Today, I volunteer to support others.

CCSYR is a non-profit settlement and counselling agency that has been serving newcomer communities in York region since 1980. Since 2010, it has supported internationally educated health care professionals through study groups and mentorship, helping them to integrate and contribute to Canada's health care system.

Like many other IMGs, I've made Canada my home, and I am deeply committed to serving its people, yet despite our qualifications and dedication, IMGs still face barriers that prevent us from contributing to the system we care about so deeply.

Out of nearly 4,000 residency positions across Canada, only about 180 are open to IMGs in the first iteration this year. Today, 6.5 million Canadians lack access to a family doctor. Our emergency rooms are overcrowded because people can't access timely primary care. It's straining hospitals, providers and patients, a gap we could ease by licensing more IMGs.

In conclusion, I respectfully urge this committee to recognize the value IMGs bring, to promote fairness and transparency in policy and to expand opportunities for supervised training and residency across Canada. All I'm saying is that we are not outsiders: We are Canadians by choice.

Thank you for your time and consideration.

The Vice-Chair (Dan Mazier): Thank you.

Antanina Hulko (International Medical Doctor, Catholic Community Services of York Region): Thank you, Mr. Chair and honourable members.

I am Dr. Antanina Hulko. Before coming to Canada, I worked as a general surgeon at the Minsk Regional Hospital, performing hundreds of operations and training young doctors. For me, surgery has never been just about skill. It's about saving lives at the most fragile moments.

In 2020, I arrived in Toronto with the dream of continuing my medical career and giving back to the country that welcomed me. When the pandemic struck, I knocked on every possible door to help. Today, five years later, I still serve Ontarians, now at the Downsview Long Term Care Centre, caring for residents with dedication and compassion, but of course not as a physician.

Along the way, I have worked tirelessly to meet every Canadian medical standard, completing the MCCQE1 and the NAC OSCE and earning my LMCC certification. I was preparing to apply for residency in Ontario when, only weeks ago, the province announced a new policy restricting eligibility for the first round of the 2025 CaRMS match to internationally trained physicians who did not attend high school in Ontario. This decision has placed many of us in an impossible position.

Despite being a Canadian citizen living, working and paying taxes here for five years, I am now not eligible to apply for residency in the very province I call home. The rules changed midway through the process, after years of effort, investment and hope. Beyond personal loss, this policy also limits Canada's ability to respond to growing health care shortages. There are hundreds of qualified physicians already here, ready to serve, if only given the chance.

I stand before you not only as a surgeon but as a new Canadian who believes deeply in this country's values of fairness, opportunity and service. My journey from the operating rooms of Belarus to the long-term care homes of Toronto reflects both my gratitude and my determination to give back.

We internationally trained physicians are not asking for special treatment, only for a fair opportunity to contribute, to return to the operating room, to care for the patients who need us and to strengthen the health care system that has become our own.

Canada gave me a home. I am ready to give it my hands, my skill and my heart.

Thank you very much.

● (1125)

The Vice-Chair (Dan Mazier): Thank you.

We'll start with our first round of questioning.

We have Dr. Strauss from the Conservatives for six minutes.

Matt Strauss (Kitchener South—Hespeler, CPC): Thank you, Chair.

Thank you, witnesses.

My questions today are for Dr. Amiri and Dr. Hulko. It was very moving testimony from both of you.

It sounds to me like you were both involved in specialist care in your home countries, or specialty training.

Ali Amiri: I was a general practitioner.

Matt Strauss: Oh, I see. Okay, in either case, I also gather that you both wrote the MCCQE.

Ali Amiri: Yes.

Matt Strauss: It is the case, and this may be news to you, that the president of the Federation of Medical Regulatory Authorities came and spoke to us and said that, if an IMG had FRCPC from the Royal College, for specialists, or if the CFPC—I always struggle with that acronym—the College of Family Physicians of Canada gave them credentials, they would have no problem achieving provincial licensure.

Are you both allowed to write those exams right now?

Ali Amiri: I don't think so. To my knowledge, we are not allowed.

The journey I'm taking is through the CaRMS application to apply for residency, because I was not specialized in my home country.

Matt Strauss: I see.

Ali Amiri: I'm applying through CaRMS, and I think that the CaRMS journey is completely different.

Matt Strauss: Dr. Hulko, is that also the case for you, that you're not allowed to write the fellowship exam for general surgery in Canada?

Antanina Hulko: Not really. I was a specialist back in my country. Potentially I would be eligible for this exam; however, unfortunately, we have a difference in the postgraduate education system that doesn't fit with the Canadian one, so residency is also my pathway.

Matt Strauss: I see. Dr. Hulko, if you were allowed to write the Royal College exam for surgeons tomorrow, would you take that opportunity?

Antanina Hulko: Absolutely.

Matt Strauss: Do you think that you might be able to pass it?

Antanina Hulko: Absolutely.

Matt Strauss: Dr. Amiri, if you were allowed to write the exam from the College of Family Physicians tomorrow, would you take that opportunity?

Ali Amiri: Yes, 100%.

Matt Strauss: And do you think you'd be able to pass it?

Ali Amiri: I do, 100%.

Matt Strauss: It seems to me that there's some problem with exam integrity. If people who have been practising medicine overseas and are Canadian citizens believe that they could pass the exam, but they're not being allowed to write the exam, there's an unfairness at the bottom of that.

Would you agree with me?

Ali Amiri: Of course. I believe, based on what I understood, that it's not about passing the exams. We have a lot of physicians. We have a lot of IMGs who went through all the qualifications and requirements, but they still don't have the opportunity to contribute.

Matt Strauss: When you both came to Canada, did you come with the understanding that you'd be able to practise medicine?

Ali Amiri: That was the reason I came here. I came here to be a physician.

Matt Strauss: Go ahead, Dr. Hulko.

Antanina Hulko: That was my dream. That was my goal as well; however, I don't think I completely realized how difficult, demanding and expensive it would be and what a long time it would take.

Matt Strauss: It seems to me that, in some ways, the right hand doesn't know what the left hand is doing. The federal health ministry says that we need doctors, and then the immigration ministry says that they'll bring some over, and then the health governing bodies, which, as we've identified, are national federal bodies that administer these exams, say that you can't even write the exams.

Would you agree with me that it just seems that there's some sort of disconnect where the administration should be stepping in here?

Antanina Hulko: For sure, and it's frustrating for us as well. At some point, it's like the requirements are here on the one hand, but, on the other hand, we take one step, and the second step is so difficult and unachievable. It takes a long time, and it takes us back from practice. There are so many obstacles, even like changing the policies midway through. Honestly, it's unfair, frustrating and unexpected.

Matt Strauss: We had the president of the Medical Council of Canada here, and he said that yes, they let people write the exams. In general, people don't have the exams ahead of time. They're difficult exams. The exams maybe don't quite prove fluency in English, but it would be very hard to pass those exams without fluency in English. He even said that this is not the case with the Royal College and family physician exams.

I'm just reflecting on your experience with the MCC. Would you agree that those were good exams, that they were fair, they were hard, and they tested your aptitude to practise medicine?

● (1130)

Antanina Hulko: In my experience, it is a hard exam, but you know what? Let's say I was a specialist and I practised a lot, but this exam, MCC, is the basic exam for all medicine. Basically, I have to recall and repeat the whole university program, even though I was a surgeon, a practising surgeon. I don't think it makes a lot of sense.

Matt Strauss: I think it's fair to say that subspecialists in Canada today would have a hard time performing on those medical school exams again, but you both have.

The Vice-Chair (Dan Mazier): You have 40 seconds.

Matt Strauss: I would put to the committee that it seems to me that all the witnesses who are coming are identifying these national exams from the Royal College and from the College of Family Physicians of Canada as really being the stumbling block. It seems unfair that you're not allowed to even write it. Let's give you an exam time and see how you perform on it.

Is either of you returning back to your home country or to other countries to practise medicine to maintain recency?

Ali Amiri: That's what we're keeping as a last resort. We prefer to stay here to serve Canadians, if possible, but as a last resort, that could be one option.

The Vice-Chair (Dan Mazier): Thank you, both.

Dr. Powlowski, you have six minutes.

Marcus Powlowski: Dr. Hulko and Dr. Amiri, neither of you is practising medicine. Is that right?

Dr. Amiri, you said you passed what used to be called the LMCC. It has a different name. It's the licensing exam Dr. Hulko referred to. I think she still called it the LMCC.

Ali Amiri: I think both of us passed all the exams, and we are applying through the CaRMS application this year.

Marcus Powlowski: You have both practised.

Ali Amiri: We are not practising.

Marcus Powlowski: I'm sorry. You both passed the licensing.

Ali Amiri: Yes.

Marcus Powlowski: Dr. Hulko, you said you had to go back and learn psychiatry and pediatrics, etc. Did you do that?

Antanina Hulko: I did, yes.

Marcus Powlowski: You passed.

Antanina Hulko: I passed everything.

Marcus Powlowski: Congratulations. That's very good.

Antanina Hulko: Thank you.

Marcus Powlowski: Have you looked at the possibility of doing practice-ready assessments? In Ontario, there are a certain number of positions, I think, offered by the College of Physicians and Surgeons. This is for general practice.

Dr. Amiri, have you looked into that?

Ali Amiri: I definitely did, but my main focus is to go to a residency here. The recency of practice is an obstacle in my journey, if I want to apply for a practice-ready assessment. It's not only for me; it's for a lot of IMGs who come to Canada. They are away from practising in a clinic. The recency of practice is something we can't have here. We don't have the opportunity. We have to go back to our countries of origin and—

Marcus Powlowski: The Ontario college said you have to have practised how recently in order to do a practice-ready assessment?

Ali Amiri: To be honest, since my focus is on the CaRMS application, I didn't go into the details of that. I prefer to go to a residency. It's not only because of that, but also because we will have other options in CaRMS.

Marcus Powlowski: Especially if you want to do a residency, that would seem to be a preferable way to go.

I believe certain provinces have some sort of bridging programs for people like you. I've heard that B.C. does. I'm not sure. I know of, for example, people who've worked as physician assistants in clinics to get up to speed in Canadian medicine.

Has that ever been a possibility for you?

Ali Amiri: This is a very good question, actually.

We have these licensing associate physician positions in B.C. and in Alberta, but they're very limited. It's really hard to get those positions.

Marcus Powlowski: Sorry, what did you call them, in B.C.?

Ali Amiri: British Columbia and Alberta have associate physician licensing programs.

Marcus Powlowski: Can you explain how that works?

Ali Amiri: I believe you're working under supervision in hospitals. It helps you get the recency of practice, but it's very limited and it's only in those two provinces, as far as I know.

Marcus Powlowski: After you do that, can you go directly into practice, or do you do a practice-ready assessment?

Ali Amiri: I think you need to go to a practice-ready assessment after that.

Marcus Powlowski: That's B.C. and Alberta. Thanks. I didn't know that was the case.

Dr. Hulko, there is a possibility, as far as I recall, from the Royal College of Physicians and Surgeons. They have a certain number of practice-ready assessments as well. Have you tried that?

● (1135)

Antanina Hulko: I would love to. However, as I mentioned before, unfortunately we have a very different system of education in Belarus. The number of years of my postgraduate training doesn't fit with the Canadian system. I'm not eligible for that.

Marcus Powlowski: Do you know if there are any bridging programs like this B.C. program, where you can work with a surgeon as an assistant to bring you up to speed?

Antanina Hulko: It's very difficult to get a clinical assistant position, but for surgery, I don't think there's anything at all. It helps you to bridge the gap in your recency of practice, but it doesn't bring you into the profession.

Marcus Powlowski: There are those kinds of assistant positions, but after finishing them, you can't go on to do your practice.

Antanina Hulko: Exactly. It keeps you in health care, but it doesn't change anything. It helps you with the gap.

Marcus Powlowski: In both of your cases, you're physicians who were trained overseas. You've both acknowledged that you perhaps need a bit more training before licensing. The systems aren't exactly the same. The training isn't exactly the same. It seems that there ought to be something tailor-made. Dr. Amiri, you'd do a one-year residency. Dr. Hulko, you'd work with a surgeon for a year or two to get you up to speed. There should be something that allows you to come up to the right standard.

I take it that there isn't anything easily available for either of you to do that.

Ali Amiri: I agree. There isn't anything available.

Marcus Powlowski: Dr. Hulko, is there nothing available?

Antanina Hulko: It's almost impossible. We have clinical assistant positions in all of the provinces, but they are not licensed. Basically, you work there, but it's not acknowledged, so it's like you're doing nothing.

Marcus Powlowski: Both of you come from countries where there might be reasons why you may not want to go back for a year or two to practise. Is that really feasible? That's one of the things we've heard. People haven't practised for a while, so they go back to their old country and do a bit of bridging, but in both of your cases, you come from countries where that's perhaps not an option.

Antanina Hulko: Exactly. It's not an option, unfortunately, in my country, because there's a war in Ukraine and my country is pretty much involved, and it's not safe for me. It's not an option, unfortunately.

The Vice-Chair (Dan Mazier): Thank you. That's the end of that round.

Now we have Mr. Thériault for six minutes.

[*Translation*]

Luc Thériault (Montcalm, BQ): Thank you, Mr. Chair.

I would like to welcome the witnesses. I would also like to welcome the witness who is joining us by video conference.

I am always a little stunned to hear the testimony of people who have a vocation, who make every effort, who pass all the tests and who persevere despite the difficulties. We have heard testimony showing that there are enormous constraints, and that is a little beyond me.

I want to understand one thing, Dr. Hulko.

You say that at this stage, after passing all the exams, a directive would declare your application inadmissible because you did not attend secondary school in the same province. Is that correct?

You must have asked what the purpose of such a measure would be. Can you shed some light on this for me?

[*English*]

Antanina Hulko: That was very shocking to me. This is the new rule, and I am trying to understand it. I know that Canada has to prioritize a lot, but honestly, I don't find it reasonable in any way, because if you are looking for competent physicians, you're not looking at where they finished their high school; you're looking at how competent they are.

I'm fine with all of these medical exams. I'm more than happy to prove that I'm competent, but high school in the same province.... It was midway, as I said, so I didn't consider other provinces, and now I'm out of the first iteration. Honestly, I feel very frustrated and a bit lost.

● (1140)

[*Translation*]

Luc Thériault: There is no rational explanation for this measure in a context of labour shortages and a shortage of doctors. Health professionals who were trained abroad and who have passed all the tests and exams are being told that they have completed all the steps, but that they did not attend secondary school in the same province.

What does this mean? Does this measure simply favour people who were born here or who arrived in the country when they were of secondary school age? I don't understand this logic. You don't seem to understand it either. Perhaps I'll ask people who do understand this kind of logic. However, it's a rather absurd position to take.

This problem has existed for 30 years. We bring people in from abroad. We tell them that they will be able to thrive in their host society. I have seen qualified people become taxi drivers. That is a total waste.

Whether there is a labour shortage or not, we say we want to welcome people properly, but we don't have the dignity to organize ourselves so that they can share their skills with us. I find that quite absurd. Although there are no stupid jobs, forcing these people, at times, to become cheap labour is appalling.

Ms. Madhany, you are surely aware that Canadian programs exist. In 2009, the pan-Canadian framework for the assessment and recognition of foreign qualifications was established. In 2010, the foreign credential recognition program was launched. In 2022, in order to promote and expand the latter program, the government invested $115 million over five years. Its goal was to help 11,000 health professionals. This year, the government has again allocated money for this purpose in the budget.

Is it effective? How did we end up in this situation? Are we helping these 11,000 people or not?

[*English*]

The Vice-Chair (Dan Mazier): You have 45 seconds.

[*Translation*]

Luc Thériault: My question is for Ms. Madhany.

[*English*]

Shamira Madhany: It has been an interesting conversation so far. The issue.... As I said, at World Education Services the recommendation we're making is that the federal government has a central role to play in coordinating a pan-Canadian workforce strategy. We have to link immigration to credential recognition and to labour market planning.

The issue at hand right now is that the federal government has the responsibility for selecting and recruiting immigrants, who come in assuming that they can practise. An individual comes to a particular province, and once they come to the province, the province has its own criteria. You've just heard about what has happened recently with doctors. Also, the licensing bodies have different processes. What you end up with is individuals who come in with an assumption that they are able to work because they have points for immigration purposes. They come to a province and then they start shopping, and they lose their relevancy.

Once again, we say that the best way to deal with this—

The Vice-Chair (Dan Mazier): You're over the time. If you could, just summarize very quickly.

Shamira Madhany: Sure. A coordinating pan-Canadian workforce strategy is what's required.

Thank you.

The Vice-Chair (Dan Mazier): Thank you.

We'll continue on to our next round.

I'm in the chair today, and I'm going to questions from the chair for the next round for five minutes.

My first question is for Ms. Madhany.

The government announced $97 million to establish the foreign credential recognition action fund. How many internationally trained doctors will this fund actually get licensed and working in Canada?

● (1145)

Shamira Madhany: The funding is critical, but what I don't know at this point, because that announcement didn't go into detail, is what the $97 million will do in terms of details. Basically, what we have heard is that it's going to be $97 million to reduce barriers, and it's one ministry at the federal government. What will be great to see are the details of the funding, to see if that's in fact going to reduce barriers. Again, it's critical to get funding, but is it going to reduce barriers so that you don't have the situation where the federal associations are doing something different than the licensing associations?

Chair, I don't have an answer to that, other than that we need more details and that we need to make sure it's a systemic approach. The funding has to be applied strategically.

The Vice-Chair (Dan Mazier): I guess I'll ask the question just for clarity.

The government announced $97 million to establish a foreign credential recognition program. We know there are a host of opportunities in it, but through this fund, how many internationally trained doctors will actually become licensed here and start working in Canada? You're saying that you have not—

Shamira Madhany: There are no details in the announcement. It basically says nothing.

The Vice-Chair (Dan Mazier): The government has not provided that number.

Shamira Madhany: That's correct.

The Vice-Chair (Dan Mazier): How many internationally trained nurses, through the government's foreign credential recognition action fund, will become licensed and start working?

Shamira Madhany: It's the same response. We know it's $97 million to reduce barriers, but there are no details around which professions and how this is going to work.

The Vice-Chair (Dan Mazier): There are no numbers. When you say details, there are no numbers of how many nurses will actually become licensed.

Shamira Madhany: That's correct. There are no numbers in terms of how the funding is going to be distributed and to which professions.

The Vice-Chair (Dan Mazier): Thank you.

Dr. Hulko, you graduated from medical school. Is that correct?

Antanina Hulko: That's right.

The Vice-Chair (Dan Mazier): Also, you completed your post-graduate medical training. Is that correct?

Antanina Hulko: That is correct.

The Vice-Chair (Dan Mazier): How long did you work as a surgeon before coming to Canada?

Antanina Hulko: I have 10 years' experience in practising surgery.

The Vice-Chair (Dan Mazier): Are you currently working as a physician in Canada?

Antanina Hulko: No, unfortunately I'm not, because I can't.

The Vice-Chair (Dan Mazier): Dr. Hulko, do you agree that there's a disconnect between the immigration system and the health care system in Canada?

Antanina Hulko: Unfortunately, I have to agree with this.

The Vice-Chair (Dan Mazier): Dr. Hulko, according to the Royal College of Physicians and Surgeons of Canada, there are 13,000 internationally trained physicians in Canada who are not working as doctors, and you are one of them. The government keeps saying that we need more immigrants to solve our health care problem, but it has failed the immigrant doctors who are already here in Canada, such as yourself.

Do you believe the government should focus on licensing immigrant doctors who are already here in Canada, before adding more people to a broken system?

Antanina Hulko: I truly believe so, and I honestly believe it would benefit Canada a lot. It would solve a lot of problems in health care. It would benefit Canadians first of all. Yes, for sure, it would be beneficial for everyone. I don't see any reason not to do that.

The Vice-Chair (Dan Mazier): Dr. Hulko, we've heard stories—and it has already been referred to—of internationally trained doctors driving taxis and working in factories across Canada. Can you share some of those stories you've heard about doctors in Canada who aren't working in their field?

Antanina Hulko: Sure. I can share my own experience, which is not so pleasant, in terms of the difference between what I'm capable of doing—what I am trained to do—and what I'm doing now. I'm working, still, in a long-term care centre. I'm helping the residents. I'm taking care of them. I am helping with their appointments in the hospitals, and I assist them. I'm happy to serve, as I said, but at the end of the day, I'm a surgeon. I'm capable of much more, and I can bring much more to Canada.

The Vice-Chair (Dan Mazier): Dr. Amiri, do you think the government should focus on licensing immigrant doctors who are already here in Canada, before adding more people to the broken system?

● (1150)

Ali Amiri: That's a good question. I think the government should focus on both. For a short-term solution to the health care crisis, I think they should focus on those who are already here and those who already meet the requirements. However, they should also encourage more physicians to come to Canada. Unfortunately, with the new policy and everything that's going on, Canada is getting a bad reputation about how it's welcoming IMGs. We need to be really careful with that. It's quite concerning.

The Vice-Chair (Dan Mazier): Okay. Thank you.

That's the end of my five-minute round.

Next, we have Dr. Eyolfson.

Doug Eyolfson: Thank you, Mr. Chair.

Thank you all for coming.

Ms. Bell, I really appreciated your comments on the value of physiotherapy. That helped me walk after a couple of back injuries and helped facilitate my discharge from St. Paul's Hospital, four days after a coronary bypass, in good enough shape to fly home commercially the next day. Very good, aggressive physiotherapy helped with that.

You talked about the certification. I know this about the medical and the nursing professions, but for a licence to practise physiotherapy, is that provincially administered, or is there a federal licence for physiotherapy?

Krissy Bell: There is a nationally recognized exam through the Canadian Alliance of Physiotherapy Regulators.

Doug Eyolfson: Okay.

Krissy Bell: That was previously offered, before the pandemic. Through the pandemic, they made some innovations to that exam, and a new national exam is set to roll out next year. Currently, clinical hours and provincial examinations are in place of that exam, but the intention is for the regulators to go back to a national exam next year.

Doug Eyolfson: Thank you.

If you are certified to practise in Ontario, do you need to apply for a separate licence to practise physiotherapy in Manitoba?

Krissy Bell: You do, yes.

Doug Eyolfson: All right. If there were a nationally recognized licence for physiotherapists—as we've been talking about for physicians—would that improve matters?

Krissy Bell: Absolutely. Even if you use examples.... With regard to physiotherapists, people think about sports right away. You think of a university sports team and a student seeing a physiotherapist as an elite-status athlete. The student will see the same physiotherapist for the entire school year. Then the student goes home and can't see that physiotherapist anymore. That physiotherapist can't treat the student anymore, because the student has crossed a border, an artificial line, which makes it so that the physiotherapist can't work with this student through the summer months.

With regard to practice borders, even here in Gatineau-Ottawa you need to be licensed in multiple jurisdictions.

Doug Eyolfson: Thank you.

Dr. Amiri and Dr. Hulko, I understand your frustration with this. I've been watching this. We've been hearing much testimony about these things.

I do want to clarify. In Ontario, the restriction is that you cannot apply for a residency in Ontario unless you've gone to high school there.

Ali Amiri: Exactly. That is correct.

Doug Eyolfson: All right.

I know this is a rhetorical question: Can you think of any public good that was accomplished by this rule?

Ali Amiri: I tried so hard, to be honest.

We, of course, understand that we want Canadians to come back home and serve their favourite people. That's definitely understandable. However, why are we not opening new opportunities for everyone to apply? Why take it from someone and give it to someone else when you can bring more opportunities for everyone, especially at this time when Canada needs physicians?

Doug Eyolfson: Absolutely, yes.

Mention was made of the CaRMS. Are you still eligible to apply for a CaRMS match if you rank residency positions in other provinces?

Ali Amiri: Actually, we have very few positions across Canada. I think that, out of 4,000, we have fewer than 180 positions across Canada. The majority of positions were in Ontario, and now we cannot apply for them. For the province of Alberta, you need to be a resident of Alberta in order to apply. For British Columbia, you need to get an invitation to apply.

If you exclude all of those things.... For those living in Ontario, they have less than 100 positions all over Canada, and there are thousands of applicants.

Doug Eyolfson: It's very unfortunate. I've watched this myself.

Would you support a national organization—an umbrella organization—that would facilitate this, as opposed to having to rely on different provinces' regulations?

● (1155)

Ali Amiri: Definitely.

Doug Eyolfson: I agree.

I have another rhetorical question.

I've spoken on this myself. I practise in Manitoba. I could drive two hours to Kenora, Ontario. They're sometimes short in their emergency department. I've often had the time to do it. I have to jump through all the hoops to apply for an Ontario licence and then pay $2,500 to $3,000 per year to maintain it.

The Vice-Chair (Dan Mazier): You have 10 seconds, Doug.

Doug Eyolfson: Thank you.

Would you agree that it would also improve the situation if licences were recognized across the country?

Ali Amiri: Definitely.

Antanina Hulko: Absolutely.

Doug Eyolfson: Thank you.

The Vice-Chair (Dan Mazier): Thank you.

Mr. Thériault, you have two and a half minutes.

[*Translation*]

Luc Thériault: I would like to continue in the same vein as my colleague, who often asks this question.

Obviously, when it comes to Quebec, there is an additional problem. There is a shortage of physiotherapists and doctors. If we allowed people to practise in one province or another, would we be robbing Peter to pay Paul? If we did that, what would it achieve? It wouldn't solve the problem. The shortage is everywhere. We're not talking about crossing the Champlain Bridge from Gatineau to practise in Ottawa and coming back to sleep in Gatineau at night. That's not what we're talking about.

I would like to understand how the mobility of doctors or physiotherapists would solve the problem. It may be a short-term solution, but not a long-term one. There is a shortage.

Ms. Bell, I'll let you respond.

[*English*]

Krissy Bell: I think there's a short-term solution in preventing any barrier to care for a patient, especially when it comes to rural and remote communities. Even in northern Quebec, you may have a fly-in community that would benefit from physiotherapy services delivered by a physiotherapist in a different province, like Ontario or the Maritimes: They could fly in, offer services for several days and then fly home. From home, they could virtually continue to care for and assess those patients who live in those fly-in communities in northern Quebec. This would be an example of expanding access by utilizing health care practitioners who may be in more urban centres.

There's an opportunity because physiotherapy has less complexity than the physician space does. We're hearing a lot about the complexity of the examinations, given the nature of the role of the physician. For physiotherapists, there's an opportunity for us to immediately make an impact on the delivery of care to Canadians because their scope can reduce the requirement for utilization of physicians. They can reduce the volume of issues in emergency rooms, etc.

I think both things are true at the same time. I do think national mobility is an important next step in ensuring equitable access for Canadians all across the country, but that alone is not the solution, for sure.

The Vice-Chair (Dan Mazier): That's great. Thank you very much.

Thank you, Mr. Thériault.

For five minutes, we'll go to Mr. Bailey.

Burton Bailey: Thank you, Chair.

Ms. Bell, in your opinion, is the health care system in Canada in crisis?

Krissy Bell: Yes.

Burton Bailey: Does population growth impact the demand on the health care system?

Krissy Bell: Yes.

Burton Bailey: Is immigration a form of population growth?

Krissy Bell: It is.

Burton Bailey: Should Canadians who have been medically trained in other countries be given priority should they wish to return to Canada and work in health care?

Krissy Bell: Yes. I think there are benefits to adding Canadians who have skills we require to support infrastructure in Canada.

Burton Bailey: Thank you.

Ms. Madhany, would a standardized national licensure system for health care professionals be a net benefit to Canadians' health care?

Shamira Madhany: Absolutely. In terms of the population decline we have in Canada, we have fewer children, we have retirements and we have an aging population. Yes, a standardized system would help Canadians.

● (1200)

Burton Bailey: Have you been consulted on immigration numbers entering Canada and the potential impact on health care here?

Shamira Madhany: As part of the consultation process that IRCC does, yes, we were part of a consultation process, but it was a broad question around the numbers of immigrants we want to bring in. It wasn't, “Do we need to bring in more health care workers?”

Burton Bailey: Can you elaborate? Yours is the first organization that's been consulted on immigration, so I'm curious to learn a little bit more.

Shamira Madhany: Sure. As part of the immigration legislation, IRCC goes across the country and basically consults on the number of immigrants they could bring into the country, what the labour market shortages are and the mix of immigrants: economic immigrants, humanitarian and family class. On that basis, it's a conversation that happens across the country, and then it comes to cabinet by early November to talk about the number of immigrants who will come and what classes of immigrants they will be.

That's the consultation process the government has to do as part of the legislation, and WES was consulted as part of that particular process.

Burton Bailey: Okay. Can you tell me of any other consultations? In Ireland and in other countries, we have Canadians who have gone and gotten their medical education. My understanding is that your organization is helping them get back to Canada and get employment.

What consultation has the Department of Health or other organizations had with you in getting more spots set up for them? Has there been any consultation in that regard?

Shamira Madhany: My organization assesses the academic credentials. That's the only component we do for immigration purposes. When somebody chooses to come to Canada, that's what we do, the academic component, not for licensing for health professionals.

Burton Bailey: Should these not take place before they come to Canada? Should we not be meeting with these students or trained medical professionals—with Dr. Hulko, for example, so that before she came she would know what she was up against?

Shamira Madhany: That's federal jurisdiction and a federal responsibility. The information that's given to potential immigrants should be very clear in terms of what the steps are to get licensed in a particular occupation. That information is fragmented right now. It isn't easily available. You end up with a fragmented situation in terms of what it takes to come here as an immigrant. There's a separate information piece in terms of what it takes to get licensed in a province. Then there's a separate piece when you go to a particular occupation.

Burton Bailey: Thank you.

Dr. Hulko and Dr. Amiri, I want to thank you both for the work you do with Catholic social services. I'm quite aware of the organization. I don't want my opening comments to reflect the work you do there. The accusation that was made by the government is what I wanted to address before this meeting.

I really feel for you, Dr. Hulko, being a female surgeon in what they refer to as the “old boys' club”. I'm really struggling with why you can't be practising as a surgical assistant. Can you elaborate on why you cannot be a surgical assistant? My understanding is that when you want to get into a residency, you need to be working in the hospital to get to know the doctors so that they give you the approval.

The Vice-Chair (Dan Mazier): Mr. Bailey, you're out of time.

We'll need a brief response.

Antanina Hulko: Speaking practically, it's almost impossible to get this position. That's it.

Burton Bailey: Thank you.

The Vice-Chair (Dan Mazier): Thank you.

Ms. Sidhu, you are next for five minutes.

Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair.

I'd like to thank all the witnesses for their insightful testimony.

Ms. Bell, you said there should be more bridging programs. There should be more programs for physiotherapists, because there's a physiotherapist shortage too. In this budget, $5 billion over three years, starting in 2026-27, will be dedicated to the health infrastructure fund. Do you think this fund will complement existing health-related...? Health care delivery comes under provincial jurisdiction. Do you think this fund will be beneficial for the bridging program and how the province wants to do that?

● (1205)

Krissy Bell: For sure, I think there's opportunity within any health investment, in particular in infrastructure, in centring consideration of all the professions on the health care team. If the infrastructure fund is utilized in a way that supports team care and advances first-contact physiotherapists, I absolutely think it could be supportive in addressing some of the barriers, including if it added national seed funding for bridging programs.

I don't have specificity around how that fund will be used, but I do think that investments in health care, as long as they prioritize consideration of the full scope and capabilities of all the professions on the health care team, and they really try to leverage the full weight of the work in the labour force, could definitely support advancing physiotherapy.

Sonia Sidhu: What role can provincial ministries and health authorities play in addressing this gap?

Krissy Bell: There are a lot of things that provincial health authorities can do. In particular, we advocate strongly for a nationalized scope of practice for physiotherapists.

Currently, from jurisdiction to jurisdiction, provincially, the scope of physiotherapists differs. If you're a physiotherapist who works in Alberta, you can order diagnostic imaging, but if you're a physiotherapist who works in Ontario, you can't. That causes a lot of backlogs and it actually increases the demand on the physician. If you go and see your GP and say you've hurt your knee or your back, they might say, “Go and see a physiotherapist,” but the physiotherapist will say, “You need an X-ray or an MRI. You have to go back to your general practitioner to get a referral, because I am not able to refer for that image,” even though it is within the competency profile in the nationalized competencies of a physiotherapist.

Recognizing the full scope of the physiotherapy profession across the country would be a massive advancement for each jurisdiction, whether that's in diagnostic imaging, the ability to refer to specialists or some of the prescribing pieces we see. We strongly advocate for a nationalized scope.

It would also support our physician colleagues. If our physician colleagues are trained and work in Ontario and they're used to their physiotherapy peers not being able to order images, and then they go to Alberta, the job of their colleagues and peers has changed because they have changed jurisdictions. As part of that consideration of mobility across the nation, a fully recognized scope of the competencies of a physiotherapist is critical.

Sonia Sidhu: Do you think there should be pan-Canadian guidelines? It's not like in Alberta. There are different procedures or guidelines to follow. How do we address this barrier? What should be done?

Krissy Bell: I think pan-Canadian guidelines are a solution. We have a very amicable relationship right across the country. Physiotherapy is quite a happy family, and we work well with our regulator partners and provincial partners across the provinces. Having consistency across those regulations, whether it's through the existing bodies or some kind of pan-Canadian framework, would for sure be a solution to ensure the full utilization and the full economic benefit of using physiotherapists and reducing the burden on the health care system.

Sonia Sidhu: Do you want to chime in on this, Ms. Madhany, from World Education Services?

The Vice-Chair (Dan Mazier): You have 10 seconds.

Shamira Madhany: Sure. Establish a federal framework to harmonize standards and make sure that people can move from province to province and contribute to the country.

Sonia Sidhu: Thank you.

The Vice-Chair (Dan Mazier): Thank you.

That concludes our first hour for the study.

Thank you to the witnesses for coming out here today.

We'll suspend for 10 minutes to get the next set in.

● (1205)

_____(Pause)_____

● (1220)

The Vice-Chair (Dan Mazier): Welcome, everybody. We're back for the second hour.

Welcome to the witnesses who are on board here.

I understand we're having some technical difficulties with Dr. Burnell, but we'll go forward with the witnesses who are in the room here today, and then we might have to take a brief suspension to get her back online and test everything.

Today, from the Canadian Association of Emergency Physicians, we have Dr. Elizabeth Shouldice and Dr. Michael Herman. Then we have the Canadian Pharmacists Association and Sadaf Faisal.

We'll start with five minutes for Dr. Shouldice.

Elizabeth Shouldice (Chair, Public Affairs Committee, Canadian Association of Emergency Physicians): Thank you for having us this afternoon.

My name is Dr. Elizabeth Shouldice. I have been privileged to serve as an emergency physician in Canada for the past 17 years.

Michael Herman (Vice-Chair, Public Affairs Committee, Canadian Association of Emergency Physicians): Thank you, Mr. Chair and the rest of the committee, for having us.

My name is Michael Herman. I'm an emergency physician. I've been practising across Canada for the last 11 years.

Elizabeth Shouldice: Canada's emergency care system is under unprecedented strain and has been for quite some time. Emergency departments across the country are the safety net of the health care system, yet the supply of emergency physicians has not kept pace with population growth, aging demographics and the increasing acuity and volume of patient presentations.

The Canadian Association of Emergency Physicians has identified the need for a sustainable national emergency medicine workforce since 2015. The findings of the 2024 EM:POWER report reaffirmed that Canada does not have enough trained emergency physicians and that existing capacity is really unevenly distributed. Physician resource planning must follow clinical service planning, which must follow patient and population needs—i.e., form must follow function.

CAEP supports efforts to address workforce shortages through the integration of internationally educated health care professionals. However, this must occur with a coordinated national framework that ensures the following: competency equivalents based on standards established by the Royal College of Physicians and Surgeons and the College of Family Physicians; fair and transparent pathways for assessment, training and licensure; and equitable distribution of emergency physicians across regions that avoids concentration in major urban centres and addresses chronic gaps in our rural and remote areas.

Michael Herman: Emergency departments are the front door to Canada's health care system. In many communities, they are the only source of 24-7 care. Their capacity to deliver timely, safe and high-quality services depends on a stable, well-trained and equitably distributed workforce.

Our EM:POWER report confirms critical emergency physician shortages across the provinces and territories. Rural, northern and smaller urban areas face the greatest challenges, leading to ED closures, long wait times and risks to patient safety. Canada requires an estimated 1,500 to 2,000 additional emergency physicians over the next decade to stabilize access.

Internationally trained physicians with emergency medicine experience represent a valuable potential resource, but the integration must align with Canadian competency standards. CAEP supports a coordinated, competency-based national assessment process that is aligned with competence by design and practice-ready assessment to ensure safe, fair and timely licensure.

Workforce distribution remains inequitable, with most certified emergency physicians concentrated in large urban centres. CAEP recommends a national distributed deployment strategy that expands domestic training capacity and supports qualified international graduates through targeted incentives, mentorship, professional development and telemedicine supports to strengthen emergency care access in high-need regions.

The EM:POWER analysis identified three pillars relevant to this study. Number one is people: ensuring a sufficient, sustainable and well-supported EM workforce. Number two is practice: standardizing training, credentialing and continuing education. Number three is place: achieving equitable access to emergency care in Canada.

Key findings relevant to this committee study are that there is a critical shortage of emergency physicians, which is predicted to worsen without national coordination, and that equitable access to emergency care requires deliberate workforce planning that distributes talent across regions.

Elizabeth Shouldice: In terms of recommendations for this committee, CAEP recommends the following.

Develop a national workforce strategy with strong federal input, using a standardized approach to data, measurement, integration and prediction. Establish a coordinated national plan to forecast, train and integrate emergency physicians based on current and projected needs. Include federal investment in EM residency expansion, rural training sites and recruitment supports.

Create a streamlined, competency-based pathway for internationally trained emergency physicians. In collaboration with the Royal College, the College of Family Physicians and provincial regulators, develop standardized, transparent criteria for assessing equivalence. Fund a national bridging program that aligns international training with Canadian EM competencies. Support practice readiness assessments tailored to emergency medicine.

Ensure equitable distribution of the EM workforce and offer incentives for those who want to practise in underserved areas. Support a well-integrated hybrid virtual care model.

Federal, provincial and territorial governments should collaborate across jurisdictions and engage CAEP, the Canadian Association of Emergency Physicians, as a subject matter expert on national advisory bodies for emergency physician resource planning and international physician integration.

● (1225)

Michael Herman: Canada's emergency care system cannot function without an adequate, competent and equitably distributed emergency medicine workforce. The integration of internationally trained physicians is part of the solution, but it must be deliberate, standards-based and aligned with national workforce planning.

The EM:POWER initiative provides a clear framework to guide this integration responsibly. The need for emergency physicians has been documented for over a decade, and the evidence now demands concentrated action. A balanced approach, one that respects patient safety, supports internationally trained professionals and ensures equitable access to care for all Canadians, is essential to sustain emergency services and uphold the public trust.

Thank you.

The Vice-Chair (Dan Mazier): Thank you.

We'll go to the Canadian Pharmacists Association and Ms. Faisal for five minutes.

Sadaf Faisal (Senior Director, Professional Affairs, Canadian Pharmacists Association): Good afternoon.

Thank you, Mr. Chair and members of the committee, for the opportunity to appear today.

I'm really pleased to be here today to talk about something that is incredibly important for our health care system and for the 47,000 practising pharmacists in Canada, including 16,000 internationally trained pharmacists, whom we represent in the Canadian Pharmacists Association.

I am an internationally trained pharmacist. After immigrating to Canada, I went through the rigorous process of obtaining my pharmacy licence. Over the years, I have practised in a variety of settings and have had the privilege of owning and operating my own pharmacy. Today, I work for the Canadian Pharmacists Association.

I came to Canada eager to contribute to patient care, but soon realized that even with years of experience, the path to licensure was lengthy, complex and filled with barriers.

Pharmacists are among the most accessible health care professionals in Canada. We are often the first point of contact for patients, whether that is managing medications, administering vaccines or supporting chronic disease care, but we are facing serious workforce challenges. The federal government's own projections show that the shortage of pharmacists will nearly double over the next decade.

Right now, about 35% of pharmacists working in Canada were trained internationally, which is the highest proportion among any health profession. That tells us two things: First, internationally trained pharmacists are essential to maintaining access to care and, second, our current domestic training capacity simply isn't keeping up. Addressing the pharmacy workforce shortage means that we need to tackle both sides of the equation. Yes, we need to do more to support internationally trained pharmacists to make licensure faster, fairer and more consistent across provinces, but we also need to grow our domestic training capacity.

Right now, Canada has about 1,400 seats nationally. That is the second-lowest capacity among the major health professions. The workforce is projected to grow by only 1.1% annually, the slowest of all health occupations. We can't rely indefinitely on international recruitment to fill that gap. We need to make sure our own schools can expand enrolment, attract new talent and produce the next generation of Canadian-trained pharmacists. That requires government investment and coordination.

For internationally trained pharmacists, the biggest challenges are structural. The licensure process can take three to five years and cost as much as $20,000, not including living costs, child care and other expenses, depending on the province.

These aren't problems of competence. These are problems of system design. Each province has its own rules, its own bridging programs and its own queues. Some provinces have only a handful of seats, and others have no structured programs at all. We need to move away from a “prove yourself alone” model and toward a supported and coordinated pathway that recognizes talent and helps pharmacists to begin practising sooner, especially in communities that are in urgent need of care.

Another key barrier affecting both internationally and Canadian-trained pharmacists is the variation in scope of practice across provinces. In some provinces, pharmacists can assess and prescribe for a broad range of common conditions, order lab tests and adapt prescriptions. In others, they can't. This inconsistency influences where pharmacists choose to work, as many prefer to practise where they can use their full skills. We recognize that scope of practice falls under provincial jurisdiction, but the federal government can help by promoting national alignment through workforce planning, funding agreements and collaboration.

We were pleased to see the foreign credential recognition investment in this week's federal budget, but we also recommend that the federal government support in other ways: one, provide dedicated federal funding for bridging and readiness programs; two, invest in expanding Canada's pharmacy education capacity; three, support consistency and transparency across provinces through shared national guidance and workforce data; and, last but not least, encourage intergovernmental collaboration to improve mobility and harmonize scope of practice wherever possible.

Canada's pharmacists, whether they are trained here or abroad, all share one goal: to care for patients and strengthen our health care system. We don't need to lower our standards to meet our workforce needs. We just need a smarter, more coordinated approach, one that values both international expertise and domestic capacity and ensures that every pharmacist can practise to full scope wherever they are.

Thank you for the opportunity to speak today. I look forward to your questions.

● (1230)

The Vice-Chair (Dan Mazier): Thank you.

We'll take a brief suspension as we have to test Dr. Burnell's equipment to see if she can join us here. Bear with us.

● (1230)

_____(Pause)_____

● (1230)

The Vice-Chair (Dan Mazier): Okay, we'll get started. Welcome back.

Unfortunately, Dr. Burnell, you'll have to just spectate, I guess. That's good old technology.

We'll start our first round of six minutes with Dr. Strauss.

Matt Strauss: Thank you, Chair.

Thank you, doctors Shouldice and Herman, for being here, and thank you as well, Ms. Faisal.

My questions are mainly for CAEP.

I can't avoid asking this one, because it's been on my mind. My wife and I are both physicians. Monday night, my son woke up unable to breathe. We were pretty sure it was croup, as he had gone to bed with a runny nose. Paramedics showed up in 10 minutes and they gave him dexamethasone on site. They took him to CHEO. My wife went with him, and I stayed home with our toddler. After a couple of hours, the nurse at CHEO said no doctor would be able to see him for eight hours so he might as well go home and they'd book him in clinic the next day.

When I reflect on it.... I know what croup is, and my wife knows what croup is. It was terribly scary, even though we know he was fine. I would have been so distressed if I hadn't had that medical background.

I'm trying to keep an open mind about it, and in many ways I'm grateful to that nurse for telling us what was really going on or the way it was going to go, but in your view, is that how it ought to go, and is that how it goes in Ottawa, Ontario today?

Elizabeth Shouldice: Thanks, Dr. Strauss, for your comment. I'm really sorry about your son. That's so stressful. It's tough for a parent, and maybe tougher for a professional, when you have that background knowledge of what's going on.

Matt Strauss: I'm an adult intensivist, so I was like, “Stridor! Intubate!”, but it's not that simple.

Elizabeth Shouldice: Right, of course.

I'm thrilled, as someone who does work in pre-hospital care in Ottawa, that he got dex pre-hospital. That's amazing.

Of course, that's not how it's supposed to go, and I think that's one reason that Dr. Herman and I work so hard on advocacy. Crowding has been a problem since you and I were both in training around the same time, and long before that.

● (1235)

Matt Strauss: Yes, and part of why I bring it up is something your testimony twigged with me. You mentioned geographic inequities in the distribution of emergency physicians. It's my understanding that it's much worse up north and it's much worse rurally.

We went to one of the biggest children's hospitals in the country, as far as I'm aware. I don't know if you have a reflection on that. If even there you can't be seen, what kind of situation are we in?

Elizabeth Shouldice: I think, oftentimes.... The colleague who preceded me as chair of public affairs for CAEP, Dr. Drummond, refers to emergency medicine as the canary in the coal mine, and he now has a lapel pin of a dead canary.

Matt Strauss: Oh, jeez.

Elizabeth Shouldice: I think we all recognize that emergency medicine, as the front door for Canadian health care, really represents what's going on in a broader scope for Canadians and for Canadian health care.

We're lucky that CHEO was open, because many of our colleagues in rural communities would show up to an emergency department that's not even open. I think we have that other layer in rural and remote communities. This is really difficult. We've started to see, over the last several decades, an incremental worsening of how emergency care can be delivered in Canada.

Matt Strauss: I guess at the base of this study is a concern that the right hand doesn't know what the left hand is doing. The immigration ministry is saying, “We need doctors; we need immigrant doctors. You're an immigrant doctor, so come to Canada.” Then the licensing bodies are saying, “No, you won't be licensed to practise here.” The immigration authorities are bringing doctors who, unfortunately, aren't succeeding at getting licensed, and they're also bringing, this year, a million new immigrants to the country.

If a million people are coming and those among them who are doctors are not able to practise, do you agree with my assessment that the right hand doesn't know what the left hand is doing and that, so long as this is the case, wait times in emergency rooms are likely to worsen?

Michael Herman: I think the population is one piece of a larger puzzle with respect to health care access. As Dr. Shouldice said, we've noticed for decades now that many of the issues facing our health care system come from a lack of resources, a lack in-patient beds and an inappropriate distribution of our workforce.

To answer your question, these are really multi-faceted issues, but they are issues that have been ongoing, I would say, for decades now—easily since the nineties.

With respect to your question about the left hand not knowing what the right hand knows, certainly one of our big aims with our EM:POWER report is to promote that coordination from the top down for the distribution and allocation of resources to fit the needs of all Canadians across the country. I think the issue is more around distribution as opposed to anything else there.

Matt Strauss: In my constituency—I serve the riding of Kitchener South—Hespeler—a lot of immigrant physicians have come to speak with me. A lot of them are not allowed to write the exam.

You both wrote exams in emergency medicine. I don't know if you did Royal College or College of Family Physicians exams. Were they good exams? Do you think that somebody who passes that exam should have a shot at working in an emergency room? What's the holdup? Why would they not even be allowed to write the exam?

Michael Herman: That's a good question, but I think it's a little outside our scope over here. The provinces regulate medical licensure, so I think that would be more of a provincial issue.

Matt Strauss: Stephanie Price, the president of the federation of regulatory bodies for all the provinces, the CPSO and their counterparts, said that if you get FRCPC, 100% of the time you will get licensure in the province. It seems to me like this exam is the holdup. That's why I'm curious to know if it's a good exam. Is it that the exam needs to be improved so that anyone can write it, and if you pass, you pass?

Elizabeth Shouldice: I think the important thing here is that the exam isn't the end point. The exam is one component of residency training. It's to look at the training that international graduates and internationally trained physicians have had, maybe in concert with an examination. It's not just the exam; it's the assessment all through residency, observation by other physicians and other things. Again, that's far outside what CAEP can comment on.

I will say that I think the exams are good. I think—

The Vice-Chair (Dan Mazier): I'm sorry, but I have to interrupt. Thank you.

Ms. Chi, you have the floor for six minutes.

● (1240)

Maggie Chi (Don Valley North, Lib.): Thank you, Chair.

Thank you to all the witnesses who are appearing today.

I am sharing my time with Dr. Powlowski.

Marcus Powlowski: Half of us over here are emergency room rejects, although Dr. Eyolfson still practises, at least a bit.

Funnily enough, I had the same situation with the same ailment at CHEO when my four-year-old started to have croup. We brought him to CHEO, and he was given dexamethasone by the nurse, appropriately so. He might have been borderline on needing epinephrine. After sitting about three or four hours, he clearly no longer needed epinephrine. We went home without seeing anybody.

I'm from Thunder Bay. I worked a lot of years in the Thunder Bay emergency room. The waiting time with Dr. Affleck, whom you probably know well.... We've seen wait times increase dramatically over the years. It used to be that we took pride in people being seen pretty quickly. Now you go to an emergency room and, not uncommonly, it takes hours and hours. This is the case right across Canada.

How much of that is a result of workforce shortage, not enough emergency room doctors?

Michael Herman: I think the issue of wait time is a multifaceted one. Workforce distribution is one of them. Health human resources of emergency physicians have been noted to be lacking, as I said in my comments. We are at a deficiency of about 1,500 physicians across Canada currently.

I think wait times really are a function of a multitude of different issues, most importantly flow through the hospital. I think it's really important to emphasize that wait times in the emergency department are a reflection of outflow from the emergency department, not inflow, meaning that the difficulty getting patients into the emergency department is truly a reflection of getting patients out of the emergency department: people who are admitted who need beds and, even further downstream, people who are admitted in hospital requiring long-term care or other community placements. When you see wait times in the emergency department, you really should be seeing that, as my colleague said, as a canary in the coal mine for the bigger hospital and health care systems issue.

While there's no one sole reason for it, these are some of the really big, important ones that should be considered in health human resources decision-making.

Marcus Powlowski: This isn't really an issue for this study, but I would suggest that you probably agree that a big part of the problem is lack of chronic care beds and people filling chronic care beds. If those were to be freed up, there would be more acute care beds. Is that right?

Michael Herman: Absolutely.

Elizabeth Shouldice: One of our colleagues says, “We can handle busy; it's crowding that kills.”

Marcus Powlowski: Dr. Herman, where do you work, in a small emergency room or in a large emergency room?

Michael Herman: I work at the Queensway Carleton Hospital in Ottawa. I also do some locum rotations in North Bay.

Marcus Powlowski: How much is the lack of emergency room doctors a factor in the closing of emergency rooms across Canada? Certainly, Helena can talk about the Okanagan. In northern Ontario, at times, emergency rooms are being closed, or there is a risk of closing emergency rooms, including Kenora. Doug, if he had national licensure, would perhaps be able to go work up there.

How much is that an issue, not having enough emergency doctors in rural Canada?

Michael Herman: It's certainly a considerable issue, and something that leads exactly to the situations you've described with physician health care shortages.

The other problem is that it becomes this sort of perverse race to the bottom. When you're competing for a very limited number of health care resources, you are essentially pitting hospitals against each other for a very limited workforce. Hospitals potentially have to provide bonuses or other financial incentives to physicians. It becomes a race to the bottom, whereas it should be a coordinated effort across a region, a province and the country, really, in ensuring there's a good distribution of these physicians across the entire workforce, not just concentrated in certain areas.

Certainly, there is lack of physicians available to staff these shifts. The overtaxed physicians who are already working these shifts are really being pushed to their limits as it stands.

Marcus Powlowski: I'll give you a little story involving Dr. Affleck and me. We were working in the Thunder Bay emergency room. I think I was in acute care, so he was the one behind, handling the calls from the region. He got a call from one of the small town hospitals where there was a car accident. I think there were multiple unstable patients, four or five. The physician was clearly overwhelmed, and probably did not have great training for working in an emergency room, let alone for multiple traumas.

Dr. Hulko, who's a surgeon from Belarus, would dearly love to work in Canada. I would suggest that if you could get people like her, with her form of training, credentialed so that they are able to work in some capacity in small towns, even if they didn't actually practise surgery all the time, that would be a tremendous benefit.

I think that in many small town emergency rooms, where you have people who aren't used to that kind of thing.... One of the big sources of anxiety that keeps people from wanting to work in those places is the worry that they're going to have to face something like that.

How much do you think we could benefit from foreign-trained people, like specialists, by getting them up to speed so they can work in rural areas?

● (1245)

The Vice-Chair (Dan Mazier): Please provide a very brief response.

Michael Herman: As long as there's an assurance of quality of care and competency of care, I think it would be one important strategy.

The Vice-Chair (Dan Mazier): That's excellent. Thank you so much.

Next, we have Mr. Thériault for six minutes.

[*Translation*]

Luc Thériault: I would like to thank the witnesses for their presence.

I think we could discuss this for an hour, but I only have six minutes to ask questions and get answers, so it’s quite frustrating.

Why is there a shortage of beds?

Elizabeth Shouldice: Thank you for your question.

[*English*]

Again, it's not the beds that are missing; it's the people to staff the beds.

[*Translation*]

Luc Thériault: When you say there is a shortage of beds, you are referring to a shortage of staff to care for patients. We agree on that point.

Are we training enough emergency room doctors? If not, why not?

[*English*]

Elizabeth Shouldice: No. This is one of the things we would like to emphasize today. It's not just making sure that we train physicians who are trained elsewhere in the world, but also increasing capacity to train emergency physicians in Canada.

Whether they've already trained as emergency physicians elsewhere or whether they've trained and finished their medical school elsewhere, we need to have some capacity within Canada, a pan-Canadian capacity, to train our own emergency physicians.

[*Translation*]

Luc Thériault: I understood your position on foreign-trained health professionals. You are willing to welcome them, but without compromising on skills, I understand that.

What I want to know is why highly qualified people end up in emergency rooms providing emergency care and services that, for many, could be provided in a clinic. It’s not just because there aren’t enough beds in the emergency room, but also because many people come to the emergency room because they don’t have access to doctors in clinics.

[*English*]

Elizabeth Shouldice: Is the question “Why is it that care is not being delivered quickly in emergency care?” or “Why is the care differing among emergency departments?”

[*Translation*]

Luc Thériault: I would say that patients who end up in the emergency room on weekends, for example, are patients who could receive the same service at a clinic. In a sense, there is a lot of congestion in the queue for emergency physicians, who should be providing specialized care in emergency cases. We were talking about waiting times, but these are often linked to the fact that there are no frontline services outside the emergency department.

Elizabeth Shouldice: Okay. I understand better now.

[*English*]

Those low-acuity patients who could be cared for in a clinic—patients with sore throats, sprained ankles—are not the ones who cause the congestion in the emergency department. The reason for congestion in the emergency department is the backdoor problem. It's that, if all our beds are filled up—with patients with congestive heart failure, pneumonia, an old person who fell—then I can't bring a patient in from the waiting room to care for them for their cough, sore throat or sprained ankle, because there is physically no space, nor are there nursing resources to care for both patients at the same time.

● (1250)

[*Translation*]

Luc Thériault: Do you triage patients in your emergency department?

Elizabeth Shouldice: Yes, absolutely.

Luc Thériault: There is therefore a number of hours of waiting time that corresponds to the triage categories. Even if these people are not the ones causing congestion in the emergency room, they are still made to wait. The common perception is that if you go to the emergency room, you won't be able to leave before having spent 16, 18 or 20 hours there. Instead, we could tell the person that if they arrive at 10 a.m. the next day, they will be able to go to the clinic and be seen.

How many emergency physicians are on duty at a hospital at night?

[*English*]

Elizabeth Shouldice: It depends on the hospital, certainly. Since COVID, at our hospital we have two physicians overnight. We used to have only one, so, certainly, that's increasing. It depends, really, on where you're working. In a larger hospital, it will be more than that, and trainees as well.

[*Translation*]

Luc Thériault: Are one or two enough? If there is only one emergency physician on duty in the emergency room at night, can we consider the emergency room to be truly open?

[*English*]

Elizabeth Shouldice: Yes, I think so. I think we've done a really good job, in many emergency departments across Canada, of trying to match physician and nursing hours to when patients arrive. If you're matching patient arrival times to when physicians are coming on shift.... At our place, a very busy urban emergency department, we now have 16 shifts a day, so we match emergency physician arrival to patient arrival. It's just that, sometimes, by nighttime some of those patients have been waiting since the day because there's no place to physically bring them into the department.

[*Translation*]

Luc Thériault: There shouldn't be many trauma cases during the night, should there?

[*English*]

Elizabeth Shouldice: That's when triage is helpful, as well as multi-tasking. It's very stressful.

[*Translation*]

Luc Thériault: I will come back to the issue of chronic underfunding later on.

[*English*]

The Vice-Chair (Dan Mazier): Thank you.

Ms. Konanz, you have five minutes.

Helena Konanz (Similkameen—South Okanagan—West Kootenay, CPC): Thank you, Chair.

Thank you to the witnesses for coming and presenting to us today, which I really appreciate, on this very serious issue.

My first question is for Dr. Herman or Dr. Shouldice. As my colleague mentioned, we have severe, chronic closures of our local emergency room in the Okanagan. In fact, it was 40 times in 2024, and I believe it's more than 30 times so far this year. These are last-minute closures. You drive up. You're presenting with some illness, or your child is, and it has just closed—a last-minute closure.

What I want to ask you is this: What kinds of challenges do you think rural emergency rooms, in particular, are facing when it comes to staffing that would cause these last-minute closures?

Michael Herman: I think you've hit on a very important topic. Rural closures are increasing in frequency and duration, and it's very serious for the communities you've identified. You would hate for somebody who is potentially having a heart attack or a stroke to come to a place they're hoping to seek care and then have to be diverted away to another location. It's a very serious issue.

With respect to some of the challenges, again, I think it mirrors many of the other challenges we see across Canada, but I think it's especially pronounced in rural areas, where there's often less of a margin for error. In smaller communities, there's a smaller physician pool to draw from and a smaller nursing pool to draw from. There often can be difficulties in recruiting and retention in these areas. Oftentimes, these are areas where, if you're working in a rural emergency department, you may have to work a 12- or 24-hour shift, which is quite difficult for people to do, even in an emergency department that is not as busy.

I think all of these contribute to difficulties in staffing these shifts. As mentioned, when there's a very limited resource pool, you have communities competing for that small number of physicians. I think one of the keys is growing the physician base you can draw from, as well as ensuring appropriate incentivization to practise in these communities and building up the supports around the physicians and nurses in these communities to make it a viable option for them to practise.

● (1255)

Helena Konanz: Thank you.

The particular hospital I was mentioning was the South Okanagan General Hospital, but in the Okanagan and the interior of B.C., there are severe shortages, not even in the rural areas, that I think could affect this also. For example, Interior Health has reported the loss of seven obstetricians and gynecologists and four psychiatrists, as well as the closure of the Kelowna hospital pediatric ward. That's a community of 150,000 or more, I believe. Would that affect the smaller hospitals around there? For example, South Okanagan General Hospital is a drive of around an hour or an hour and a half from that hospital.

Elizabeth Shouldice: I think these are really important and stressful times for any community. When we look across the country, very few emergency departments are fully staffed. Very few emergency departments don't have holes in their physician schedule. We draw on each other to fill those holes and work above and beyond what we have agreed to work.

CAEP is undergoing a redo of our 2015 study to look at health human resources, particularly physician resources across the country, using both quantitative and qualitative data: Why are you as a physician retiring early? Why are you stopping working in the emergency department? How long do you think you're going to work? That process is happening right now. I think it will give us a lot more of that information.

I think what we took from our EM:POWER report was that we really need some accountability for physician resources and for the delivery of health care across the country, and we need to look broadly at the health system—not just at an individual, siloed hospital but at the health system overall. I think that's one reason we're hoping to engage this committee to look at having a pan-Canadian approach to these health human resource problems.

Helena Konanz: You mentioned burnout earlier. That's probably a very big aspect of these closures.

Elizabeth Shouldice: Absolutely. I graduated from medical school in 2005. I've been in practice for a long time now. I'm firmly a mid-career physician, which is shocking to me some days. I've seen levels of burnout in our colleagues like we've never seen before. Since COVID, it's just been getting worse. I think a lot of people are leaving more acute care specialties because of that burnout. It's an important point.

The Vice-Chair (Dan Mazier): Thank you.

Ms. Sidhu, you have five minutes.

Sonia Sidhu: Thank you, Mr. Chair.

Before I start, if CMA is not able to chime in, can they submit their opening remarks?

The Vice-Chair (Dan Mazier): Yes.

Please do so, by all means.

Sonia Sidhu: Thank you.

Dr. Shouldice and Dr. Herman, thank you for your 17 years and 11 years serving on the front lines. That's a long time.

In the last Parliament, we did a study on addressing Canada's health workforce crisis. We heard then that there was an administrative burden on doctors and that the digital health era was coming. What is your view on digital health? Do you think it will ease the administrative burden and give the best outcomes for patients?

Perhaps you can both give your views on that.

Michael Herman: We are certainly in an era of some exciting digital tools and digital programs, with certain artificial intelligence applications that have some potential for assistance. I think that any strategy, be it digital or otherwise, really needs to be done with the engagement of the physician and nursing workforce. Certainly in the past.... I think anyone who has worked with an electronic health record system can see that some of these systems are touted as being this panacea that will cure all of our ills, but it's a very top-down, imposed structure that doesn't necessarily work with the workflow of individual organizations or departments.

As with any of these strategies, I think it's important that they're integrated in consultation with the frontline providers who are delivering that care, to ensure that it actually meets the clinical needs and solves the problem for them. I'm certainly hopeful that some of these innovations can provide some benefit, but I think anything has to be given deliberately and carefully with the frontline providers in mind.

Sonia Sidhu: Can AI triage tools be helpful?

Michael Herman: Again, there's some preliminary work that I'm personally familiar with, but I think we're still in the very early days of some of this technology. I'd be hesitant to claim it as a solution to the problems.

I think that, as with any tool, it can be used for good or bad. One has to make sure it is being used appropriately and actually providing measurable benefits that can be quantified for the frontline providers.

● (1300)

Sonia Sidhu: Environmental impacts, like some viruses.... Does it impact that? There should be operational strategies in emergencies. Do you have any in the Ottawa hospital?

Michael Herman: I'm sorry. I didn't quite make out the question.

Sonia Sidhu: I mean the environmental impacts from allergies and viruses.

Elizabeth Shouldice: This was something that was addressed in our EM:POWER report, as well as in disaster planning.

With COVID, obviously, we learned a lot about what we need to do in terms of disaster planning. It's something that we addressed in our national forum on emergency medicine last April or two Aprils ago. I think it's really important that we realized we need to do a better job at a hyperlocal level, just in our own hospitals—what are we going to do if something happens?—and then bringing that more broadly.

Sonia Sidhu: Thank you.

I want to share my time with Mr. Eyolfson.

Doug Eyolfson: Thank you, Mr. Chair.

Thanks to all of you for coming.

I've been a proud CAEP member since 1998. I graduated in 1993 and then finished the Royal College program in 1998, when it was still a very new residency.

Thank you for your comments about the outflow. I don't know if you know Dr. Wes Palatnick from Winnipeg. He always gave a flow diagram that showed rooms with successively smaller outlets and showed exactly where the problem was, but the opening to emergency was a big wide funnel, so there was no wide opening except going in. It's been a frustration.

The Vice-Chair (Dan Mazier): You have one minute.

Doug Eyolfson: Thank you.

Again, when we talk about workforce, Dr. Powlowski mentioned this. I worked in Winnipeg. I could hop across the border to Ontario, but I don't have a licence. I used to have a licence in Ontario. I surrendered it because I wasn't working much, and I still had to pay an extra $2,500 a year for something I wasn't using.

We have tried to come up with a coordinated strategy where, even if it isn't one licence, the licence could be recognized, so that if I had a Manitoba licence, I could hop across and do the same job in Ontario, or in the Northwest Territories if they need it. Any time we've tried this, we've gotten a lot of push-back from provinces, saying that this is federal and “stay in your lane”.

Would your organization be willing to help lobby the provinces to work with the federal government to get a strategy so that we can help with this distribution, so that even if people are working in these concentrated urban centres, they would have more mobility to occasionally go to these isolated areas?

The Vice-Chair (Dan Mazier): You're past your minute.

Please give a 10-second answer.

Elizabeth Shouldice: Yes, absolutely. I think there's been some success with that in Atlantic Canada. They have done that on their own, and I think it's been terrific.

Yes, of course.

Doug Eyolfson: Thank you.

The Vice-Chair (Dan Mazier): Thank you.

Mr. Thériault, we can continue with your question.

[*Translation*]

Luc Thériault: Is there a shortage of doctors or not? Is there a scarcity of doctors or not?

[*English*]

Elizabeth Shouldice: Yes.

[*Translation*]

Luc Thériault: Is it, among other things, because we are not training enough and we do not have the necessary funding to do so? It is the same for pharmacists. We need to have the resources to train more doctors, instead of limiting the number of training places.

Earlier, we were talking about the fact that there are only 77 vacancies in physiotherapy. Medicine has been facing the same problem for a long time; we knew that one day there would be a shortage. What’s more, students decide, and it’s their choice, not to go into certain specialties. For example, I imagine that people who like adrenaline will go and work in emergency medicine, but we don’t train enough of them.

I’d like to understand something. My colleague keeps coming back to the issue of sharing resources between provinces. Earlier, we were talking about competitiveness between hospitals. I think that in a context of shortage, there is going to be a problem. I agree with sharing if the intention is to send a firefighter from Ontario to put out a fire in Manitoba, but that is temporary. In the long term, that is not what we need. We need to take structural measures. We are in an emergency situation, and fires are breaking out everywhere. That is why we need to talk to each other and coordinate, but ideally, that is not what we want. We want a health care system that does not suffer from chronic underfunding.

● (1305)

[*English*]

Elizabeth Shouldice: Yes, of course. I think we recognized, in 2015, that we were missing emergency physicians already and that it was only going to get worse. We projected this with a CAEP study back in 2015, so we've known this for a long time.

I think pan-Canadian licensure or sharing licensure between provinces or regions is only one small piece of the puzzle, but it can be very helpful, particularly in our rural and remote communities. There's been some success with this in Ontario. Dr. Herman goes up to North Bay from time to time to give some help to their emergency department, as a small example.

Yes, you're right. That's not the ultimate panacea or solution, but it is one small piece of the puzzle.

The Vice-Chair (Dan Mazier): That's it. Thank you, Mr. Thériault.

I guess we're going to the next round.

As chair, I'm doing double duty today, so I'll kick off the next round for five minutes. My question will be for Dr. Shouldice.

The government announced $97 million to establish the foreign credential recognition action fund. How many internationally trained doctors will actually become licensed and start working in Canada through this fund?

Elizabeth Shouldice: I wouldn't have a way to answer that right now. I don't have enough information to know how many that would license. There are so many components to that, so I'm not sure.

The Vice-Chair (Dan Mazier): Has the government told you? Has it consulted, or did it tell you anything about this $97-million fund?

Elizabeth Shouldice: That wouldn't fall under our purview at CAEP. That would fall under the provincial licensing bodies, and that's not really our purview.

The Vice-Chair (Dan Mazier): Then you wouldn't know how many internationally trained nurses that $97 million would actually....

Elizabeth Shouldice: No.

The Vice-Chair (Dan Mazier): Okay. Thank you.

I will switch my time over to Mr. Bailey.

Burton Bailey: Thank you.

Dr. Herman, how many spots are there for training emergency room physicians in Canada?

Michael Herman: That's a good question. I don't have those numbers off the top of my head. I'm sure—

Burton Bailey: Can you guess?

Michael Herman: Again, I couldn't give a reasonable answer.

Burton Bailey: Okay, I will find that number.

I was part of a study in Alberta, and that study claimed that emergency physicians are seeing half the number of patients since COVID, and a lot of it is the administrative burden. Would you agree with that statement?

Michael Herman: I would agree that certainly the administrative burden is one of the obstacles that emergency physicians are facing. With respect to seeing fewer patients, I think it's more that the patients we're seeing are more complex and more involved, requiring more specialized care.

Burton Bailey: Thank you. Yes, they have more comorbidities.

It's also been indicated in some of the provinces that due to the lack of surgical capacity, emergency rooms are becoming parking lots. We're not operating in the evenings like we used to, pre-COVID. We're finding that there is not the same availability, so patients are waiting extra days for their surgeries, which is creating a burden on emergency room physicians.

Would you agree with that statement?

Michael Herman: As we said, emergency department crowding is an outflow problem. This certainly reflects one of the outflow challenges that we face.

Burton Bailey: Okay. I'll take that as a half answer.

I'm now going to ask a few questions of your colleague.

In your opinion, is the health care system in Canada in crisis?

Elizabeth Shouldice: Yes.

Burton Bailey: Thank you.

Should the federal government's immigration levels be proportionate with health care infrastructure and human resource capacity?

Elizabeth Shouldice: I think that's a really difficult question to answer, and it's one that I'm not sure I can answer appropriately.

Burton Bailey: Thank you.

The Vice-Chair (Dan Mazier): You have a little more time. Do you want to give it back to me?

Burton Bailey: Sure. Thank you.

The Vice-Chair (Dan Mazier): I'll just take advantage of this time, as we have some housekeeping items to clean up here.

We were mentioning this before with the Liberals, regarding an extension of the women's health study. We're trying to get a witness list, and we've been working with the clerks, back and forth, so they can give some explanation of what's going on with that. We're asking the committee for a one-week extension for the supplementary report, for the women's health study.

Is everyone okay with that?

Some hon. members: Agreed.

● (1310)

Sonia Sidhu: I have a point of order, Mr. Chair.

Is it not Mr. Eyolfson's time?

The Vice-Chair (Dan Mazier): I'm still on my time. He handed it back over to me, so instead of wasting time at the end, I thought I would just get these things cleaned up.

Sonia Sidhu: Okay.

The Vice-Chair (Dan Mazier): The other thing is, of course, a reminder from the clerk that the deadline for witnesses for the antimicrobial study is today, and next week for the Canadian pharmaceutical sovereignty study.

I'm still within my time, Ms. Sidhu. Who's next?

Mr. Eyolfson, you're next for five minutes.

Doug Eyolfson: I must move a motion to adjourn the meeting, it being 1:10 p.m.

The Vice-Chair (Dan Mazier): Okay. Very good.

Thank you to the witnesses for coming here today. Enjoy your afternoon.