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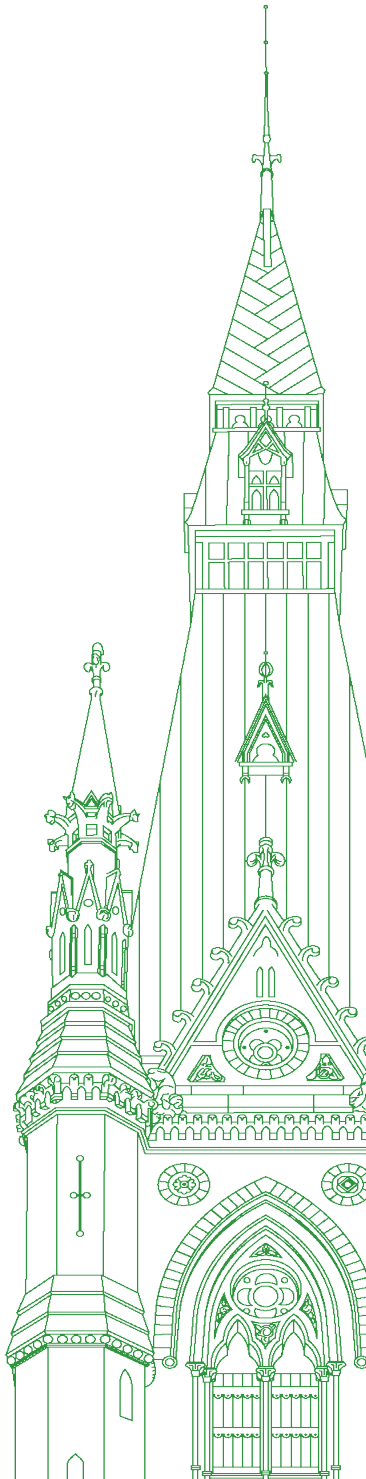

Chair: Hedy Fry

Standing Committee on Health

Thursday, November 27, 2025

● (1105)

[*Translation*]

The Chair (Hon. Hedy Fry (Vancouver Centre, Lib.)): Good morning, everyone.

[*English*]

I call this meeting to order.

[*Translation*]

Welcome to meeting number 14 of the House of Commons Standing Committee on Health.

We acknowledge that we are meeting on the unceded territory of the Algonquin Anishinabe people.

[*English*]

Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders.

I want to go over some of the basic guidelines.

Please remember to turn off your microphone when you are not speaking. Please remember to leave your device somewhere on the decal you see in front of you on the table so that it doesn't interfere with the sound and bother the people who are doing the interpretation.

[*Translation*]

Andréanne Larouche (Shefford, BQ): Madam Chair, I have a point of order. There's no interpretation.

[*English*]

The Chair: You're not getting translation.

Can you hear me now?

[*Translation*]

Andréanne Larouche: I can't hear you, Madam Chair. I don't know if the machine is defective, but I'll try another one.

[*English*]

The Chair: I don't know. Let's find out what's going on.

We'll suspend until we hear what's going on and get Madame Larouche set up.

● (1105)

_____(Pause)_____

● (1115)

The Chair: We'll resume the meeting.

Just for the sake of our witness, I would like to say to please turn off your mic when you're not speaking and turn it on when you're speaking.

Please understand what the term "going through the chair" means: It means you're not allowed to talk to each other across the room. If you have a question, ask for a point of clarification. The chair will then make sure that happens. For whatever points you wish to make, go through the chair, please. It just makes life much easier.

I would like to welcome Ms. Houston.

We will give you five minutes to present. I will literally say, "one minute", and then "30 seconds", just to give you a heads-up so that you can end. If you cannot finish everything you wish to say, there will be a question and answer session in which you will probably be able to elaborate on some of the things you wanted to say.

I'll begin now. We have before us our witness, Dr. Patricia Houston, vice-dean of medical education at the Temerty faculty of medicine.

Dr. Houston, you have five minutes for your opening remarks.

Dr. Patricia Houston (Vice Dean, Medical Education, Temerty Faculty of Medicine, University of Toronto): Thank you very much for inviting me here today, Madam Chairperson.

First and foremost, I would like to apologize for the internal miscommunication that occurred at Temerty Medicine that caused some delay in my appearance. It is certainly an honour for me to be here today to answer your questions and to speak about medical education and how it contributes to Canada's health care system.

As you have stated, my name is Dr. Patricia Houston. I'm a practising anesthesiologist and critical care physician, and I have done this for over 40 years. I currently practise at St. Michael's Hospital in Toronto, but I have also had many leadership roles over the course of my career. Currently, as of 2020, I am the vice -dean of medical education at the University of Toronto's Temerty Faculty of Medicine, where I'm a full professor. In this role, I am responsible for the MD program, postgraduate medical education programs, continuing professional development programs, the office of learner affairs and our integrated physician scientist training programs, and, most recently, I took on the oversight of our expansion to our Scarborough campus.

This study topic is important. All Canadians want a health care system that has the capacity and the resilience to meet the needs of our patients, our families and our communities. The University of Toronto has a long history of leadership in medical education. We are the largest single contributor to practising physicians, representing over 20% of newly trained Canadian doctors who graduated into practice in 2024.

Medical education is a long, complicated and complex process, so with your indulgence, I would like to outline the journey very quickly. I apologize in advance to my physician colleagues who are members of this committee and are very familiar with this, but I think it is important context.

After completing an MD program, whether it be at U of T, another Canadian medical school or an international medical school, all learners must go on to the second part of their education: postgraduate training, which most people know as medical residency. The reason it's called the residency is in the very old days, even before my time, these trainees actually lived in the hospital and thus were called residents. Residency training can range from two years for family medicine to over seven years for programs such as neurosurgery.

The number of provincially funded residency positions is determined by the province in collaboration with the educational institutions and our health care partners. Temerty Medicine trains physicians across more than 80 accredited postgraduate specialty, subspecialty and family medicine programs. Our family medicine program is one of the largest in the world: In 2024, 32% of newly graduated family doctors who trained in Ontario and went into practice in Ontario graduated from the University of Toronto.

We also have internationally trained physicians who enter the health workforce in Canada through one of three pathways.

First, there are international medical graduates, or IMGs, who have Canadian citizenship or permanent resident status. These learners have gone abroad to complete medical school and have returned home to complete their residency requirements. They must go through the CaRMS R1 PGY1 match process and they are eligible for our publicly funded residency positions across Canada.

Second, there are internationally trained physicians who are fully certified to practise. They have completed both undergraduate and postgraduate education. If they satisfy immigration and licensing requirements to practise, they enter practice in Canada.

The third pathway, which I think is what you want to speak about today, is for internationally funded trainees. Canada is known around the world for its high-calibre medical education system. By design, we have created spaces for internationally trained doctors who are funded to come to Canada temporarily to train and then return home, and most are funded by governments or institutions. We train both residents and fellows who go on to a subspecialty, which is very specialized training, after their residency.

● (1120)

We at Temerty Medicine are proud to serve Canadians and the Canadian health care system. I welcome any questions you might have about the work that we do.

The Chair: Thank you very much.

I now go to the question and answer segment. The first is a six-minute round. It means that every question and answer must be done within six minutes. Once again, I will give the questioner and the person answering the opportunity to be as precise and as concise as possible so we can get enough questions in.

I begin with the Conservatives and Mr. Mazier for six minutes, please.

Dan Mazier (Riding Mountain, CPC): Thank you, Chair.

Welcome, Dr. Houston.

Dr. Houston, how many foreign doctors did the University of Toronto train last year through the visa trainee program?

Dr. Patricia Houston: Last year, in total, we had 459 physicians in this program.

Dan Mazier: That's in the residency program.

Dr. Patricia Houston: That's in the residency program—

Dan Mazier: Thank you.

Dr. Patricia Houston: —and the fellowship program, so it's the total of residency and fellowship....

Dan Mazier: How many returned to their home country after training?

Dr. Patricia Houston: They are all expected to return to their home country. It is part of the contract that we have with their sponsor and that the trainee also signs on to.

Dan Mazier: How many visa trainees completed their training at the University of Toronto last year?

Dre Patricia Houston: I don't have that exact number, but I can provide it to you. They range from PGY-1s to PGY-7s. We accept between two and four residents into family medicine, and they return after two years. Those in the Royal College specialty and subspecialties train for a variable number of years, depending on the residency program.

Dan Mazier: So, do you have a rough idea? Is it, like, 1,000 or 500?

Dr. Patricia Houston: Oh, no, it's not that large. If we have 459 in the program, the maximum we could send out in any given year would be 459.

Dan Mazier: Okay, if you could forward that information, that would be great.

Dr. Patricia Houston: I will certainly give you the information as to how many graduated last year.

Dan Mazier: Okay.

How many Canadian medical students graduated from the University of Toronto last year?

Dr. Patricia Houston: The current cohort is 303 students who came in. Last year, I believe we graduated 259 students.

The reason for the discrepancy is that we have expanded our medical school numbers, our cohort, in the last years due to increased funding.

Dan Mazier: Okay, yes. I got my number. Thank you so much.

How much does a single Saudi sponsored visa trainee pay to the University of Toronto per year of training?

Dr. Patricia Houston: The trainee does not pay the University of Toronto any dollars. The sponsor pays us $100,000. They also provide the salary and the cost of living for accommodations for the trainee.

● (1125)

Dan Mazier: So, the sponsor would be the Saudi Arabian government.

Dr. Patricia Houston: It's either the government or.... There are individual institutions in Saudi Arabia and the other five Middle Eastern countries that send these funded trainees.

Dan Mazier: Do you have any idea of how much the total amount is?

Dr. Patricia Houston: Do you mean the total amount that comes into the University of Toronto? Well, our usual number is between 450 and 500 trainees per year, so if you do the math, that's between $45 million and $50 million.

Dan Mazier: Wow.

Dre Patricia Houston: It is a significant amount of money that provides funding for our education and research programs.

Dan Mazier: So, it's $100,000 per student—

Dr. Patricia Houston: That's per year.

Dan Mazier: What were those numbers again?

Dr. Patricia Houston: As I told you, last year we had 459. We usually have between 450 and 500 of these learners.

Dan Mazier: Does the money that the University of Toronto collects from foreign-funded visa trainees go into the faculty's general revenue, yes or no?

Dr. Patricia Houston: Yes and no.

Dan Mazier: Okay.

Dr. Patricia Houston: I'm happy to expand on that.

Dan Mazier: Yes.

Dr. Patricia Houston: The money first comes into the postgraduate medical education office.

Dan Mazier: How much? What percentage?

Dr. Patricia Houston: All of the money initially comes into the postgraduate medical education office. We then determine how much money is needed to support the education programs, both centrally in the postgraduate medical education office and centrally across the medical education program.

Dan Mazier: So, those—

Dr. Patricia Houston: Then we distribute the money to the departments. Subsequent to that, we send whatever money is still remaining to the dean's office for use to support other education and research activities.

Dan Mazier: So, it goes into general revenue first, and then you decide where it's going to go after that.

Dr. Patricia Houston: It comes to the postgraduate medical education office first.

Dan Mazier: That is considered general revenue.

Dr. Patricia Houston: It is for the postgraduate medical education office.

Dan Mazier: Okay. Can you table all that information?

Dr. Patricia Houston: I am happy to provide you with that information.

Dan Mazier: Okay.

Is there anything requiring the University of Toronto to use foreign visa trainee funding to expand medical training for Canadians?

Dr. Patricia Houston: No.

Dan Mazier: No?

Dr. Patricia Houston: No. The funding for the expansion of programs for Canadians is provided by the Ministry of Health or by MCURES.

It doesn't go directly to the expansion of the programs. It supports all of the programs, the existing—

Dan Mazier: So, it goes into general revenue, and then you decide where it goes. It doesn't go back into funding programs.

Dr. Patricia Houston: It supports all of the programs, not just specifically the expansion programs. I'll give you an example. It is also used to support our office of learner affairs.

Dan Mazier: It could go into artwork for the walls. It could go into anything into the university.

Dr. Patricia Houston: We take responsibility for the use of the funds, and I would be happy to provide you with what the expenses are within education.

Dan Mazier: Yes, that would be very good if you could table with the committee what funds are visa trainee revenues and where they are deposited. That would be great.

How much money, in total, did the University of Toronto receive last year from foreign governments to train visa trainee doctors?

Dr. Patricia Houston: The amount of dollars that I just explained to you: the $45 million approximately, for the 459 trainees we had last year.

Dan Mazier: Before accepting the money from foreign governments, do you evaluate that country's human rights record?

Dr. Patricia Houston: We do not. In the postgraduate medical education office, that is not our role.

The Chair: Thank you. Your time is up.

Dan Mazier: Thank you, Chair.

The Chair: I now go to the Liberals.

Mr. Eyolfson, you have six minutes, please.

Doug Eyolfson (Winnipeg West, Lib.): Dr. Houston, thank you for coming out here.

On these visa trainees we're talking about, I just want to confirm. This is part of your testimony, but I want to get this so that there's no confusion. These are funded by the governments that send these people, and these are not funded by provincial or public funds. Is that correct?

Dr. Patricia Houston: That is correct.

Doug Eyolfson: Thank you.

There may have been a misunderstanding as well regarding whether these trainees are taking residency positions from physicians who are eligible to practise in Canada. Does that happen?

● (1130)

Dr. Patricia Houston: It does not.

Doug Eyolfson: All right. Thank you.

You said that it is the province that is determining how many medical residency spots you have.

Dr. Patricia Houston: That is correct.

Each year, the Ministry of Health determines how many residency positions there are across the institutions in Ontario. It used to be six. It is now seven.

We work with the ministry to determine in which of the programs—family medicine and the Royal College specialties—they would like those spots attributed to. We then work at the university with the departments to ensure that we have the numbers, in collaboration with the Ministry of Health. Then we put those numbers into CaRMS. Every year at the University of Toronto, we have the good fortune of filling all of our positions.

To give you some context, through the CaRMS match, we match to 183 family medicine spots and 276 Royal College spots, for a total of 459 residents that go through the PGY-1 match. We have a total of Ministry of Health-funded residents of 1,865 spots.

Doug Eyolfson: Thank you.

On this funding you received for the visa trainees, you said that it goes to support the postgraduate programs. Could you expand on what kinds of things this money helps support in the postgraduate programs?

Dr. Patricia Houston: It is first used at postgraduate medical education essentially to provide the funding for all of the administrative structures within postgraduate medical education: the outreach programs; the admissions process; the registration process, because all of our learners must be registered with the College of Physicians and Surgeons of Ontario; our curriculum office, which develops and helps to support curriculum; our accreditation office; our student and learner assessment office; and all of the supports for our learners that we have available through our learner affairs office, which includes supports for learner wellness.

Doug Eyolfson: Thank you.

Is it fair to say that this funding these governments provide for these visa trainees helps to support all of the residents in your programs?

Dr. Patricia Houston: That would be very true, yes.

When we think about these visa trainees, not only are they supporting education, but they are essential at this time to the health care that is delivered across our hospitals in our Toronto Academic Health Science Network.

Doug Eyolfson: All right. Thank you.

What would be the effect on your postgraduate programs at the University of Toronto if this program were to be cancelled and this funding were to suddenly disappear?

Dr. Patricia Houston: It would be a difficult situation.

We faced this in 2018 when some of the Saudi learners left us, and we had a reduced number of Saudi learners for a number of years.

We do have the reserves and the capacity to manage, but it would be difficult. We would also have to work with our hospital partners to ensure that there were enough health care professionals to backfill for the health care needs that were previously filled by these visa trainees.

Doug Eyolfson: Thank you.

Having gone through a Royal College residency myself, as I believe Dr. Strauss across the way has, I'm very familiar with the workloads at night and sometimes having to be in two places at once, literally. When you don't have enough staff, of course, we've seen the outcomes when you don't have enough people to manage the problems.

Are these trainees contributing to patient care and patient safety in the hospitals?

Dr. Patricia Houston: They absolutely are. They also contribute to the education of the more junior residents, the medical students and the other health profession learners in our environment.

Doug Eyolfson: Our latest federal government budget in 2025 involves some increased investments for increasing international talent.

Can you very briefly describe whether there's any strategy to take advantage of this funding?

Dr. Patricia Houston: Our president is very committed to working with the federal government. This is a huge opportunity, not just for the University of Toronto but also for all of Canada, to attract career scientists and post-doctoral and doctoral fellows to come to Canada and improve our ability to meet the needs of our communities for the future.

● (1135)

The Chair: Thank you.

I'm going to go to Madame Larouche from the Bloc Québécois.

[*Translation*]

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

Andréanne Larouche: Thank you very much, Madam Chair.

Dr. Houston, are you on the French channel?

[*English*]

Dr. Patricia Houston: I don't have any interpretation.

[*Translation*]

Andréanne Larouche: Madam Chair, did anyone explain to the witness how to access the French channel before the meeting?

My time is being eaten up.

[*English*]

Dr. Patricia Houston: It's coming now.

[*Translation*]

Andréanne Larouche: Madam Chair, can you reset the clock, since there was a technical issue?

[*English*]

The Chair: All right.

We paused when you asked that question.

[*Translation*]

Andréanne Larouche: Thank you very much.

I'll begin my intervention, which will be for six minutes.

Dr. Houston, while answering one of my colleague's question, you talked about what happened in 2018.

In 2018, you lost about 800 medical trainees because of a diplomatic dispute between Canada and Saudi Arabia in 2018–2019. Students were at risk of not receiving their scholarships.

At the time, the Canadian Medical Association Journal wrote that what began as a symbiotic relationship may have led to a dangerous dependency, evolving now to the paradox of an understaffed program and unmatched trainees. It also said that Canada's health and education systems must never be vulnerable to the spontaneous decisions of a foreign government.

That's what happened in 2018-19. What was written in the Canadian Medical Association Journal is significant.

You even said that you unfortunately lost people in 2018. It's quite troubling to see how dependent Canada is.

[*English*]

Dr. Patricia Houston: You mentioned the number 800. It was a significantly lower number than that, because, again, it is not just Saudi Arabia. We had learners from Kuwait, the U.A.E., Bahrain, Oman and Qatar. It was a much smaller number of learners who left, and most of them have returned.

The year 2018 was a wake-up call for all of us. We recognized at that time the vulnerability of relying on this funding, and we have since ensured that, as needed and when needed, we will be able to continue to support our educational and academic programs.

As well, what we do have, should there be more provincial funding, is the capacity at this time and into the future to increase the number of residency positions that we could fill if funded by our provincial government.

[*Translation*]

Andréanne Larouche: Okay.

Earlier, you gave some figures on what these students bring. Your faculty has training agreements with Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates. I'll come back to this later, but these countries are not necessarily known for upholding human rights.

You gave some figures, but I'd like to have an idea of percentages. What percentage of your residency program budget comes from agreements with those five countries?

[*English*]

Dr. Patricia Houston: Of the learners we have from these countries, approximately 40% are from Saudi Arabia, 30% are from Kuwait, 20% are from the U.A.E. and the remainder from the three other countries.

[*Translation*]

Andréanne Larouche: My question was more about what percentage of your residency program budget comes from agreements with those countries.

[*English*]

Dr. Patricia Houston: I didn't get the question.

The Chair: Is your interpretation not working?

Dr. Patricia Houston: It was previously, but I didn't get that question.

The Chair: Okay.

I will suspend while we check out what's going on here.

● (1135)

(Pause)

● (1140)

The Chair: We're back.

You haven't lost your time. We always stop the clock when anyone has a problem.

[*Translation*]

Andréanne Larouche: I'm not looking for the percentage of students who came from each of those countries.

What I want to know is what percentage of your residency program budget comes from agreements with those countries?

[*English*]

Dr. Patricia Houston: Yes, it's approximately 8%.

[*Translation*]

Andréanne Larouche: That's a lot.

Do you think it's a good idea for a Canadian public university to rely on these third countries to fund clinical and postgraduate training? I still think 8% is a high percentage.

Despite the advice of the Canadian Medical Association Journal, do you think it is healthy to be so dependent on other countries?

[*English*]

Dr. Patricia Houston: As I stated previously, we understand the vulnerability, but should this funding cease, we would be prepared to manage at that time.

[*Translation*]

Andréanne Larouche: The university is not immune to mood swings from one of these five countries.

You told one of my colleagues that your role isn't to take human rights into account. Given the criticism some of these regimes face regarding human rights, is the University of Toronto evaluating the ethical implications before reaching new agreements or renewing the current ones?

[*English*]

Dr. Patricia Houston: The University of Toronto has a very diverse environment and it is committed to working with our global partners. This is an opportunity for us through training these physicians; they go home to their home countries and take back with them the values that we instill through our programs.

[*Translation*]

Andréanne Larouche: In one of its blog posts, the Canadian Association for Medical Education says the need to move away from this reliance on third-party funding goes hand in hand with recognizing the inappropriateness of large-scale reliance on the pharmaceutical industry and medical device manufacturers to pay trainees and fund training programs.

The association believes there is too much dependence in that regard. I'll come back to it in another round unless you have a brief comment to make now.

[*English*]

The Chair: Thank you.

I'll now go to the second round. This is a five-minute round. I will do the same thing, so I'll give you time to round out your questions and answers.

We'll begin the second round with the Conservatives and Mr. Strauss.

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

Dr. Houston, do you know how much money came to postgraduate medical education at the University of Toronto, specifically from Saudi Arabian sources last year?

Dr. Patricia Houston: If we say that Saudi Arabia represents approximately 40% of the learners, and we got $45 million, I would say it was $18 million.

Matt Strauss: Well done. That was fast math. Thank you.

Does the University of Toronto—particularly the Temerty school of medicine—receive other sources of funding from Saudi Arabia other than that, in terms of donations or other partnerships not directly associated with the visa trainees?

Dr. Patricia Houston: Not to the best of my knowledge.

Matt Strauss: You mentioned this episode in 2018. I was on a medical faculty at that time. I remember it very well.

To say it into the record again, Chrystia Freeland was then the foreign affairs minister. She criticized the Saudi government, which was putting women in prison because they had the temerity to advocate for their right to drive. From my recollection, medical faculties lobbied Global Affairs Canada and Chrystia Freeland, who happens to be the member of Parliament for most of the University of Toronto's medical school, to temper her criticism, let's say.

Are you aware that officials at University of Toronto lobbied Global Affairs Canada or the then-minister of foreign affairs to temper her criticism of Saudi Arabia in order to protect this funding?

Dr. Patricia Houston: I am not aware of that occurring.

Matt Strauss: Okay.

We've spoken a lot about the difference between, let's say, funding and capacity. It seems to me pretty obvious that if the University of Toronto currently has the capacity to train Saudis, but the funding is coming from Saudi Arabia, if some other source were to provide that funding, and the Government of Saudi Arabia was not given those residency spots.... Like, if that funding was restored from some other source, the University of Toronto could, for instance, train Canadian IMGs who want to come back home.

Dr. Patricia Houston: We have the capacity at this time and have put forward to the provincial government a further expansion plan for our residency program. The short answer is, yes, we could further expand the number of residents we graduate in any given year.

● (1145)

Matt Strauss: An association that represents these Canadian graduates from Irish, Australian, U.K., American and Caribbean schools said that often these folks will drum up their own funding, but this funding is not accepted by faculties of medicine. Does your faculty have a policy about this? If I have an Irish medical degree, and my hometown of St. Thomas, Ontario, says they will fund my residency, would you accept those funds the way you accept funds from the Kingdom of Saudi Arabia?

Dr. Patricia Houston: That is not allowed by the provincial government. The provincial government for both the MD program and the postgraduate medical education programs sets the total number of domestic spots available.

Matt Strauss: I see.

The Kingdom of Saudi Arabia is a brutally repressive dictatorship. Shortly after this episode in 2018, they lured a Washington Post journalist into their Turkish consulate. They dismembered him with a bone saw. This repression continues to this day. They executed somebody for tweets critical of the government this past summer.

Do you have any concern that the Temerty medical faculty is compromised by receiving money from this type of source? Do you think the faculty, for instance, is able to condemn these practices in Saudi Arabia, or would that risk their funding?

Dr. Patricia Houston: It is not my role. I do not take a role in the political arena. I do take a role in ensuring that we support the education of these trainees who come to us—

Matt Strauss: I'm going to interrupt you for a second there.

So the Temerty Faculty of Medicine does not have a view on whether women should be allowed to drive?

The Chair: May I say that their view on whether women should be allowed to drive may be off topic?

Matt Strauss: I think it's directly on topic.

The Chair: Go ahead. You have one minute left.

Dr. Patricia Houston: The Temerty Faculty of Medicine would not put forward a view on that.

Matt Strauss: Okay.

Women's College Hospital is part of the Temerty Faculty of Medicine. It doesn't view itself as a feminist institution that promotes equal rights for women in Canada and abroad?

Dr. Patricia Houston: Women's College Hospital is one of the TAHSN hospitals.

Matt Strauss: It doesn't take a view on women's rights globally?

Dr. Patricia Houston: I have not recently reviewed whatever they have put out about this.

Matt Strauss: I have one last question. We received an email from a member of the University of Toronto medical faculty—

The Chair: You have 16 seconds.

We will need the shortest answer possible.

Matt Strauss: —who wishes to remain anonymous because of fear of reprisal from the administration. He says that the impression of rank-and-file faculty is that the Saudi money is used to prop up the growing administrative structure and roles of the faculty rather than improving the training quality and experience of Canadian learners.

Is there a reason you can think of why he would want to remain anonymous for fear of reprisal?

Dr. Patricia Houston: I cannot.

Matt Strauss: Thank you.

The Chair: We now go to the Liberals for the second round.

You have five minutes, please, Ms. Sidhu.

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

Dr. Houston, my question is about the shortage. We continue to hear that many specialties face persistent workforce shortages that impact on wait times and service access. The committee has heard from other witnesses that the internationally sponsored help address the health care workforce shortage. Can you expand on that?

Dr. Patricia Houston: Could you ask your question again?

Sonia Sidhu: Some specialties have shortages. Persistent workforce shortages impact wait times in hospitals and service access. Can you expand on how the internationally sponsored help address this health care workforce shortage?

Dr. Patricia Houston: Well, they absolutely do provide significant service in the hospitals to our patients and to the health care system. Yes, at this time, each resident who is working in our system is contributing up to 50 or more hours per week of work that would otherwise have to be done. At this time, we have a crisis in human health resources. It would not be easy to backfill that.

That is why we all must be looking at how we increase the number of health care professionals—not just doctors, but health care professionals—to meet the needs of our communities.

Sonia Sidhu: Dr. Houston, you did talk about IMGs. One in three IMGs is a Canadian citizen or permanent resident returning home after studying abroad.

How can federal and provincial partners better support these Canadians who want to complete their residency training here? Also, you said that you have put forward a further expansion plan to the province. Can you expand on that?

● (1150)

Dr. Patricia Houston: Certainly.

Those IMGs—those are the Canadians and permanent residents who study abroad—are eligible to go through the IMG stream and match in the first iteration of the CaRMS matching system and then again in an unblended way, to go through the second match of the CaRMS matching system.

The way to increase their access to residency positions is to increase the number of residency positions. We have put forward to the government...we were given an additional 67 postgraduate medical residency positions in the expansion that occurred, and we could certainly take many more.

Sonia Sidhu: The other thing I just want to highlight is budget 2025 introduced a $5-billion health infrastructure fund, including support for hospitals and medical schools.

How could this investment help expand training capacity and support the learning environment for the future physicians?

Dr. Patricia Houston: I think it can be used to build medical schools. I laud our provincial government for the two new medical schools in Ontario, at TMU and at York. It can be used to refurbish our medical schools, some of which have not had their physical structures addressed in decades. It can be used to build new hospitals and new research labs, because we can't just do the education, we must be doing the research and innovative work, as well, in order to not just increase the number of health care workers but to improve the health care system.

Sonia Sidhu: Thank you.

I also want to say that budget 2025 includes significant investment to attract international talent to Canada, including to support recruitment of international doctoral students and post-doctoral fellows and new support for universities.

You talked about TMU. I'm very pleased TMU in Brampton is getting $25 million, but how is the faculty of medicine planning to take advantage for the specialties, like some special doctors, because surgeries are not happening because there's a shortage—

The Chair: You have one minute.

Sonia Sidhu: —so, on the specialty side.

Dr. Patricia Houston: The funding, as I understand it, is to recruit scientists but many of those scientists are clinician scientists. Certainly as we look to who we recruit, it should be for those areas of science where we can best support them and where they are needed, and that often aligns with the clinical needs as well.

As well, we would be able to recruit post-doctoral and doctoral learners and fellows and, again, contribute to the rich science that is done by the University of Toronto and by Temerty Medicine, which has led to us being ranked in the top 10 in the world.

Sonia Sidhu: Thank you.

The Chair: You have 14 seconds.

Sonia Sidhu: I'll pass it on.

The Chair: Thank you. That's good.

I'll go to Madame Larouche.

[*Translation*]

Ms. Larouche, you have the floor for two and a half minutes.

Andréanne Larouche: Thank you, Madam Chair.

Dr. Houston, I'd like to go back quickly to the human rights issue.

In an effort to successfully conclude an agreement with Saudi Arabia, and to avoid frustrating and offending Saudi Arabian representatives, the Prime Minister recently said his international policy was no longer feminist.

What percentage of women residents come from Saudi Arabia and the other countries we have agreements with?

[*English*]

Dr. Patricia Houston: I do not have that number, but I would be happy to provide it to you.

[*Translation*]

Andréanne Larouche: That's perfect.

You talked a little about percentages and other sources of funding for your university. Would your faculty be willing to transform some of the residency positions funded by foreign states into positions for Canadian permanent residents and citizens?

[*English*]

Dr. Patricia Houston: Absolutely. We are ready and able to expand our capacity.

We are expanding to Scarborough, which is an under-serviced area, and we have recently expanded to the Simcoe-Muskoka region with the opening of two family medicine teaching units, one in Orillia and one in Midland. They have a capacity to expand even further.

[*Translation*]

Andréanne Larouche: What would you need to reduce dependency on foreign programs?

● (1155)

[*English*]

Dr. Patricia Houston: As we expand our programs with provincially funded learners, we will absolutely be creating those physicians and health care providers to serve the province of Ontario. They will not bring in the tuition, $100,000 a year, that the internationally funded students do bring to us, so there would be a difference in the funding to the University of Toronto if all of those positions were replaced by Canadians and permanent residents.

The Chair: Thank you.

Now I go to Mr. Bailey for the Conservatives.

You have five minutes, please.

Burton Bailey (Red Deer, CPC): Dr. Houston, the University of Toronto's mission statement reads:

> The University of Toronto is dedicated to fostering an academic community in which the learning and scholarship of every member may flourish, with vigilant protection for individual human rights, and a resolute commitment to the principles of equal opportunity, equity and justice.

Do you think that the Kingdom of Saudi Arabia shares these values?

Dr. Patricia Houston: I can't comment on that.

Burton Bailey: I'm sorry?

Dr. Patricia Houston: I haven't looked at the mission statement of the Kingdom of Saudi Arabia.

Burton Bailey: No, that's your university's mission statement that I just quoted.

Dr. Patricia Houston: I understand that, and I'm very supportive of our mission statement.

Burton Bailey: Okay.

Dr. Patricia Houston: As part of our mission, we work with multiple partners around the globe.

Burton Bailey: Okay. Will you condemn the human rights abuses committed by the countries you've received funding for? Yes or no?

Dr. Patricia Houston: I choose not to respond.

Burton Bailey: All right. I will take that answer.

Do you personally—

Dr. Patricia Houston: I don't see that it is something that I need to answer to.

Burton Bailey: I want you to know that you've really given us great answers. We've had a whole bunch of witnesses, and I really appreciate the information you've been giving us.

What I am trying to determine is, if a Saudi Arabian person can take that spot, what does it take for us to get an IMG in that same spot? Is it $100,000?

Dr. Patricia Houston: No, it's provincial funding.

Burton Bailey: I realize that, but when we see this budget—

Dr. Patricia Houston: So it's not $100,000.

Burton Bailey: When we see this budget that has just been set out, how many extra spots are we going to create across Canada? I'm thinking, well, $97 million could possibly create 1,000 more medical specialist graduates if we used the money correctly.

Some of my questions are trying to get to that answer. Are we using this money correctly? You mentioned that you have all these spots. Now, I'm going to call the Saudi ones extras, and we're going to call the ones that you currently have medical students for as domestic spots.

Dr. Patricia Houston: That's correct. I call them domestic and supernumerary.

Burton Bailey: How can we increase those domestic spots? What type of dollar figure do we need to have? I understand that you want it to be provincial, but could you indicate to me a dollar figure per year per student for a resident on a five-year program, not in family medicine but a specialty? Is it $100,000? Is it $50,000? Is there a number?

Dr. Patricia Houston: Yes, there is a number. Let's start with medical school, because you can't have a resident unless you put a student through medical school. It costs approximately $80,000 a year to put a medical student through the MD program—per year, one student, one year—at the University of Toronto.

The reason the tuition for the postgraduate medical education programs is $100,000 for the Middle Eastern countries is that it's approximately the cost to support that residency position.

Burton Bailey: Thank you.

Now, other universities that I have spoken with have received donations. You indicated that the University of Toronto has not received any donations towards any expansions or anything from the Saudi government, just $100,000 per student. There's been no extra kindness.

Dr. Patricia Houston: I said that to the best of my knowledge. I was not aware of any other donations from the Saudis to the Temerty Faculty of Medicine, and these are not donations; this is tuition that they pay.

Burton Bailey: Thank you.

I feel really bad for these IMGs that we have in Ireland.

I'm from Alberta. We have 44 students who want to come back to Alberta and do the CaRMS match. They're not having any success. They're finding difficulty. The Alberta government is now looking at creating spaces, and I guess they will associate a number to increase those IMGs. What would it take for your university to increase spots?

● (1200)

Dr. Patricia Houston: It would take, first, the province saying they would support the expansion and, then, the funding from the province for those spots.

Burton Bailey: Do you have any concerns about Canadian universities' dependence on the visa trainees from Saudi Arabia, a theocratic monarchy alleged to have committed human rights violations, including state-sanctioned murders and the oppression of women and minorities, and curbing freedoms daily?

Dr. Patricia Houston: The University of Toronto trains those physicians to take the values of the Canadian health care system and our university back to improve their health care system.

The Chair: Thank you very much.

I now go to Ms. Chi from the Liberals.

You have five minutes, please.

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

Thank you, Dr. Houston, for appearing today. For the record, who determines the number of public-funded residency positions and their allocation?

Dr. Patricia Houston: It's the Ministry of Health in the province of Ontario.

Maggie Chi: What does that process usually look like? Each year you go to the province with a number of spots, and.... Can you outline those steps for us?

Dr. Patricia Houston: Sure, I'd be happy to take you through the process. I'm going to speak specifically about the University of Toronto. First, we meet with the Ministry of Health, and they tell us, through a transfer payment agreement, how many residency positions—this is the total number of positions, from PGY-1 to PGY-7—they will support for the upcoming academic year. They also give us direction as to how they want those spots distributed—first and foremost, between family medicine and the Royal College of Physicians and Surgeons spots and, then, their preference as to which Royal College specialties should increase in number or, at some times, decrease in number.

We then take that information back. We have a committee, at which we ask every program to send to the committee their capacity for the upcoming academic year. Usually their capacity is more than the number of spots that we have funded. We then sit down at a subcommittee of our postgraduate medical education advisory committee—and this committee is called the allocation committee. Collaboratively, we decide on this many spots to family medicine, this many spots to Royal College and how many across the different specialties. We come to consensus and agreement. We send it back to the Ministry of Health for their approval, then we go forward with our plan and we submit it to CaRMS for the next year.

Maggie Chi: Thank you, Dr. Houston.

On the expansion, you mentioned UTSC...or the medical school. How many additional spots does it provide?

Dr. Patricia Houston: In that expansion, we got 44 new MD spots in addition to our base of 259 spots. We got 67 postgraduate spots: 40 are in family medicine and only 27 are in the Royal College spots. Of the 27 of those, 12 were taken away, in a prior iteration of adjustment of residency spots, so there were, truly, only 15 in addition to what we had previously had in postgraduate Royal College spots. That is why I'm saying that, for a program as large as ours, we have capacity to further expand.

Maggie Chi: I want to dwell on the UTSC piece because—

Dr. Patricia Houston: Sure. I'm happy to talk about Scarborough.

Maggie Chi: —as you know, in Scarborough, the east end of the city is very underserved.

Dr. Patricia Houston: It is one of the worst in Ontario.

Maggie Chi: Yes. Do you find that the graduation rate from the UTSC campus will help with the capacity in that region?

Dr. Patricia Houston: That is our hope. The 44 spots are in place. It was just this year that we went up to the total of 44. We will not be opening the Scarborough campus for the MD program until fall 2027 because the building isn't open. Our experience, in our prior expansion to UTM, when we expanded by 54 spots in 2010, was that they stay.

This has also been borne out by the work that's been done by NOSM. If you train them in a community, many of the medical students and postgraduate trainees go on to stay in the community. Another example of that is the family medicine teaching unit we opened in Barrie, at Royal Victoria hospital, in 2009. Most of their graduates have stayed in that community, which, again, is an underserviced community.

Maggie Chi: Thank you so much.

I will share my time with Dr. Jaczek.

The Chair: Dr. Jaczek, you have one minute.

Hon. Helena Jaczek (Markham—Stouffville, Lib.): Thank you so much, Madam Chair.

Dr. Houston, I've just come to this committee from the science and research committee. Of course, as you noted and has been discussed, our budget 2025 is looking to attract international expertise to come back, particularly on the research side. You mentioned, specifically, post-doctoral fellows potentially being part of that attraction to Canada. Are there specific areas of specialty, in terms of the types of medical assistance, that are crucially needed, perhaps, at this point?

● (1205)

Dr. Patricia Houston: I think that we need to do work in the neurosciences. I think Alzheimer's and neurodegenerative neurocognitive disorders are a particular concern with our aging population. We have a strength in this in Toronto through our Toronto Academic Health Science Network. Cardiovascular disease and cancer, of course, will always be something that we have a burden of. I think that really looking at health systems, not just who the doctors are and what the research is but the research around how to make a better health care system, is something that we have to explore.

The Chair: Thank you very much.

I now suspend the meeting.

● (1205)

_____(Pause)_____

● (1210)

The Chair: I am resuming the meeting with the witnesses who are here.

Once again, we have witnesses present in the room: Ms. Amber McPherson, who is an emergency medicine physician; Dr. Marie Dagenais, from the National Dental Examining Board of Canada; and Dr. Meredith Irwin, pediatrician-in-chief, department of pediatrics, SickKids hospital.

I will just run over the process quickly. You each have five minutes to present. I will give you a one-minute yell, and then a 30-second yell so that you can wrap up. If you can't finish what you need to say, it will actually, hopefully, come out when you're getting into the question and answer sessions.

I will now begin with the opening remarks.

Dr. Amber McPherson, you have five minutes, please.

Dr. Amber McPherson (Emergency Medicine Physician, As an Individual): Thank you, Madam Chair and members of the committee.

My name is Amber McPherson. I'm a U.S.-trained, board-certified emergency medicine physician with 12 years of experience prior to moving to Ontario earlier this year.

I came to Canada because I was increasingly frustrated by practising in a system where patients are routinely bankrupted by life-saving or even routine medical care. I wanted to work in a country where access to basic health care is a right, not a privilege.

I'm not alone. Many U.S.-trained physicians feel this way, especially recently. A growing number of American physicians are seeking to leave a system where evidence-based medicine is becoming increasingly politicized. We want to practise in countries where science, equity and public health are supported not only by professional organizations, but by government policy. Canada, as our nearest neighbour, is a natural first choice.

Unfortunately, Canada's licensing and immigration processes are so burdensome, disorganized and inconsistent that many physicians give up before even arriving. In my own case, I spent months in back-and-forth communications with British Columbia's licensing bodies, trying to determine whether I qualified for a licence. I had connections on Vancouver Island and a likely job offer, but the answers I received were inconsistent and ultimately inconclusive. I eventually shifted my attention to Ontario, where I was finally able to obtain my certificate to practise.

Once licensed, I was able to secure a job almost immediately, and I chose to join the Waterloo Regional Health Network, where I am happy practising today.

Like any immigrant, I hope to obtain permanent residency to reduce long-term uncertainty and build a stable future in Canada, but the pathway is far from straightforward. For example, Ontario has a provincial nominee program with a specific stream for physicians, yet the program currently excludes most U.S.-trained specialists.

The issue is a terminology mismatch. The College of Physicians and Surgeons of Ontario issues what is called a “restricted certificate” even though it allows full independent unsupervised practise with no time limit. The only restriction is that we must practise within our specialty—in my case, emergency medicine.

Why would the provincial nominee program create a pathway for physicians that is effectively inaccessible to nearly all immigrant physicians? It's almost certainly unintentional, but it represents a significant and unnecessary barrier for physicians who simply want to live, work and contribute permanently in Canada.

This reflects a broader pattern across the country. Regulatory bodies, immigration programs, provincial ministries and federal frameworks operate in silos. Their requirements do not align and internationally trained physicians get stuck in the gaps.

Until I obtain permanent residency, my legal status is tied to a single work site, preventing me from providing locum coverage elsewhere. Locums are an effective way to support rural and remote communities. Many physicians, including me, enjoy providing part-time coverage in high-need areas, but delays in immigration status limit our flexibility, as does the lack of reciprocity between provincial licensing bodies.

It's important to emphasize that the clinical differences between the U.S. and Canada are minimal. We follow the same science and evidence and similar standards of care, yet licensure pathways vary dramatically between provinces, and the process can be opaque even within a single province. Several of my colleagues in the U.S. are interested in practising in Canada but cannot obtain a clear answer about eligibility.

● (1215)

In contrast, in the U.S., while licensing is state-based, the criteria are transparent. If you meet objective requirements and have no history of misconduct, you know you will qualify before you invest extensive time and money in the process of applying. Given the rigorous standards of U.S. medical training and board certification, there's no reason why Canadian provinces should not implement reciprocal or streamlined licensing for most specialties.

For all of these reasons, I strongly support national licensure standards and a more coherent, streamlined pathway to permanent residency for internationally trained physicians, particularly those from equivalent training systems like the United States.

The Chair: Thank you very much.

I now go to our next witness, Dr. Marie Dagenais, executive director and registrar of the National Dental Examining Board of Canada.

Dr. Marie Dagenais (Executive Director and Registrar, National Dental Examining Board of Canada): Good afternoon. Thank you, Madam Chair and members of the committee, for the opportunity to appear.

[*Translation*]

My name is Marie Dagenais. I am a dentist and the executive director of the National Dental Examining Board of Canada, or NDEB.

[*English*]

The NDEB was created by an act of Parliament to establish and maintain a national standard for the practice of dentistry in Canada. The NDEB is a not-for-profit organization supported by examination fees. All dentists, regardless of citizenship or country of education, are required to successfully complete our examination prior to licensure.

The dental profession in Canada maintains reciprocal agreements with the United States, Australia, Ireland and New Zealand. These agreements recognize the equivalency of dental education and facilitate licensure for graduates from those jurisdictions. However, internationally trained dentists. ITDs, from countries without such reciprocal agreements must demonstrate equivalency through one of two routes: the completion of a two- to three-year university bridging program or the completion of the NDEB equivalency process, which is a structured assessment pathway.

Global dental education varies widely in curriculum, clinical exposure and assessment standards. Since the establishment of our equivalency process in 2011, over 12,000 ITDs have taken at least one of our examinations, but only 25% have completed all of the examinations and achieved certification. The success rate for our equivalency process varies between 33% and 93% between countries, and 35% and 98% between universities.

The examinations administered by the NDEB are essential safeguards to ensure public protection. Dentistry is a profession in which practitioners often work independently, alone and without supervision. Therefore, a standardized and independent assessment of competence is critical.

Canada is facing significant health human resource challenges and this includes dentists. Although the current number of dentists appears sufficient, there is a problem in terms of distribution, with shortages in rural areas. Effective workforce planning is also necessary to support the CDCP, which funds oral health care for low-income residents.

Enrolment in Canadian dental programs has remained unchanged for a decade, producing fewer than 600 graduates, including ITDs enrolled in bridging programs. The ESDC projects that dentistry is at a strong risk of shortages between 2024 and 2033. The ESDC further indicates that a substantial increase in school leavers would be needed to prevent a shortage.

An important government initiative toward addressing the health human resource challenges has been the prioritization of health-related occupations through the express entry system. While this approach appropriately seeks to strengthen Canada's health workforce, the inclusion of dentistry in invitations for health care professionals may unintentionally create unrealistic expectations among immigrants regarding their ability to obtain licensure in Canada. Prioritizing immigration candidates based on an academic credential in dentistry offers limited practical benefits in addressing Canada's oral health workforce needs.

Health Canada's ethical framework for recruiting and retaining internationally educated health professionals, IEHPs, emphasizes the need to avoid increasing the number of underutilized IEHPs and to support those already in Canada. In alignment with this principle, the NDEB recommends that the federal government remove dentistry from the health care occupations included in dedicated immigration invitations and prioritize permanent residency pathways.

The NDEB also recommends collaboration between governments, regulators and academic institutions to expand seats in accredited dental programs for both domestic and ITDs to increase the support for new dentists and help meet projected population needs.

Finally, the NDEB recommends that a plan be developed to address the distribution issue through collaboration between the government, provincial regulators and academic institutions.

[*Translation*]

Thank you very much.

● (1220)

The Chair: Thank you, Ms. Dagenais.

[*English*]

I'd like to now go to Dr. Meredith Irwin, who is the pediatrician-in-chief at SickKids hospital.

Dr. Irwin, go ahead.

Dr. Meredith Irwin (Paediatrician-in-Chief, Department of Paediatrics, The Hospital for Sick Children (SickKids), Representative, Pediatric Chairs of Canada): Thank you.

Honourable members of the Standing Committee on Health, it's an absolute privilege to provide testimony today on behalf of the Pediatric Chairs of Canada, PCC.

As you've heard, I'm the pediatrician-in-chief and also the chair of pediatrics at the University of Toronto and The Hospital for Sick Children.

PCC is a national network of our academic child health leaders. We are dedicated to strengthening the future of pediatrics by working together to advance education, research and the excellent care of our children, youth and families. We also oversee the training of the next generation of specialized expert pediatric physicians across Canada.

PCC and Children's Healthcare Canada, our sister organization, have been advocating to put children back at the centre of policy-making. Investing in children's health yields measurable social and economic returns.

As you know, Canada's children have a right to health care. Right now, our collective ability to deliver this care in a timely way to children and youth increasingly depends on the strength of its highly specialized pediatric workforce. Today, that workforce is at risk.

Across the country, pediatricians and subspecialists, whose expertise is essential when children require preventative care, specialized treatments or coordinated diagnostics and management of complex conditions, are in very short supply. Importantly, pediatric subspecialists in areas such as cardiology, oncology and neurology are not interchangeable with those who care for adults and are significantly fewer in number.

There are more than eight million children currently living in Canada, and this number will increase by 24% over the next 50 years, yet across many jurisdictions, children now wait longer than adults for essential care, not because their needs are less urgent but because our workforce is too small, aging and increasingly stretched to meet the needs of an increasingly complex population of children.

To better understand the scope, PCC in 2024 conducted a national data collection focused on pediatric subspecialty physicians, the workforce and the trainees who are currently preparing to enter these fields. Our findings showed that shortages are causing delays in access to essential care, jeopardizing the short- and long-term outcomes of our children. Fewer trainees are choosing pediatrics, resulting in a shrinking workforce attempting to serve a growing, increasingly complex pediatric population.

As you've heard, there are insufficient provincial residency spots to train a sufficient number of Canadian pediatric subspecialists to meet the current demand. Finally, and importantly, there are delays in hiring internationally trained pediatric subspecialists, including Canadians trained abroad. This threatens service delivery, teaching and capacity building, as well as research and innovation.

Today, highly trained pediatric subspecialists, many urgently needed to maintain services, face unnecessary delays in immigration, protracted licensing timelines and systemic obstacles, preventing them from joining the workforce in a timely manner.

These barriers are not just administrative. They translate into longer work times, longer wait times for children, increased pressures on our hospitals, closure of programs and lost opportunities.

PCC would like to submit the following recommendations to the committee.

We suggest streamlining immigration processes, such as paperwork, authorizations for work permits and visas, creating faster, clearer pathways for permanent residency for pediatric specialists and other subspecialists.

We feel we need to prioritize pediatric subspecialists in existing immigration streams, such as express entry. We suggest harmonizing and coordinating licensure requirements across provinces and territories to reduce variability, as well as developing national standards for recognizing training from countries with similar standards and, finally, creating and expediting consistent—

● (1225)

The Chair: You have one minute.

Dr. Meredith Irwin: —licensure.

We would support federal and provincial initiatives, including encouraging collaboration with the immigration groups who control that, as well as the provincial ministries of health and medical regulatory authorities.

We need to ensure that the pediatric workforce is counted as part of the broader HHR strategies that our government is putting important focus on, especially subspecialist care.

I want to highlight this is not just about physicians. It's about other specialty health providers who provide expertise care, such as nurses, psychologists and others, for children.

In conclusion, addressing the pediatric workforce requires coordinated, national-level action. PCC believes the federal government has a critical role to play to strengthen this pediatric workforce, both strengthening our domestic training pathways while also modernizing—

The Chair: You have 13 seconds.

Dr. Meredith Irwin: —immigration and credentialing as our way to get physicians here now.

I look forward to answering any questions and providing examples if they would be helpful.

Thank you.

The Chair: Thank you very much.

I'm going to go to the question and answer session. It begins with a six-minute session. That six-minute session includes both questions and answers. I will be giving you the call out at one minute and again at 30 seconds so that you can wrap it up. I will not be allowing people to go over time, because we have a time limit on a committee meeting. Thank you.

To begin the questions and answers, I go to the Conservatives and Ms. Konanz for six minutes, please.

● (1230)

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

Through the chair, my first questions are for Dr. Irwin.

Thank you for coming in today. Your testimony was really informative and also disturbing in a lot of ways.

Dr. Irwin, the pediatric unit at the Kelowna hospital in my region was forced to close for several months amid a doctor shortage. While it has since reopened, I don't believe it's open to full capacity at this point.

How common is it for pediatric health care to be suddenly unavailable to a community the size of Kelowna, with nearly 200,000 people? This hospital also services the entire interior of B.C., basically, for pediatrics. How common is that?

Dr. Meredith Irwin: I think that in pediatrics, probably like many specialties, the numbers are often fewer than they would be for adult caregivers or adult specialists to serve a similarly sized population.

I don't know the exact numbers in your riding, but I would suspect that the total number of physicians available at that hospital to provide pediatric services may have been under some strain, and perhaps it got to a critical number, such that there were not enough doctors to provide safe health care.

Again, I don't know the details—

Helena Konanz: Excuse me; is that common? Is that a common thing to happen throughout the country?

Dr. Meredith Irwin: I think it can be.

I can give you some examples from Ontario or from some of the groups that I'm more aware of. I'll give you a very different example.

I'm a pediatric oncologist, so I care for children with cancer—

Helena Konanz: Thank you.

Dr. Meredith Irwin: We in Ontario, in Toronto, provide bone marrow transplants for children essentially east of Ottawa, or from Ottawa and eastward. We have only five physicians, and it took a lot of work to recruit them to provide bone marrow transplants.

If any of those physicians leave, we will not be able to do what we can do. If more than two were to leave, we would potentially have to close the program.

Helena Konanz: Have you closed, then?

Dr. Meredith Irwin: We have not needed to—

Helena Konanz: Okay, you're close.

Dr. Meredith Irwin: —but four out of those five are internationally trained physicians. We were not able to identify Canadians.

Helena Konanz: What risks are possible in care to our children if a hospital lacks a pediatric unit? If someone says to me, “Oh, well, they'll just go to another unit,” tell me what the risks are.

Dr. Meredith Irwin: That's a really important question.

As I alluded to, we are not the same. We train very differently in pediatrics. We do four years of training in pediatrics after medical school graduation, and then in our subspecialties. For oncology, that's another three years of hematology and oncology.

We take care of different conditions, whether that be in kidney, heart, etc., and so physicians—

Helena Konanz: Then it's a very dangerous situation.

Dr. Meredith Irwin: —would not have exactly the same expertise.

Helena Konanz: Do you predict that at some point there are going to be pediatric units closing permanently? Would you say that we may come up with an excuse or that administration might come up with an excuse like, “Well, it'll be covered in other areas”?

Of course, you don't believe that and it doesn't sound like it's possible.

Dr. Meredith Irwin: I do not believe that would be safe and high-quality care for our children.

Helena Konanz: But you see that coming down the road, it sounds like.

Dr. Meredith Irwin: I see it being a risk, especially when we have a strained workforce.

Again, there are multiple specialties. There's general pediatrics, which is probably a big part of the population you're speaking about, but there are also many specialties under strain. We know that more than half of our current pediatric cardiologists, the cardiologists practising across the country who take care of our youngest children, are over 50, and over 20% are over 60. That tells you something about that workforce.

Helena Konanz: So it's a very dangerous situation.

Is pediatric medicine that's taught in schools in Australia, America or the United Kingdom, let's say, comparable to medicine that's taught in Canadian medical schools, and would it be interchangeable in the sense that we could receive doctors from those countries and they should be able to fit right in with our pediatric requirements?

Dr. Meredith Irwin: I believe so. Dr. McPherson spoke about that.

As you may have seen in my biography, I am a Harvard-trained physician. I did my medical school at Harvard. I did my residency at Boston Children's and Dana-Farber—

Helena Konanz: Yes. Okay, then it's very similar.

Dr. Meredith Irwin: I believe it is incredibly similar. We have standards that we follow, and I—

Helena Konanz: Of course; of course you do. Thank you so much.

Dr. McPherson, thank you for your opening statements. You said that Canada's licensing is “burdensome, disorganized and inconsistent”. It's pretty clear what you feel about it and what we've been hearing from witnesses.

It sounds to me as though Americans want to leave and want to work here. Would you say that Canada is getting a bad reputation in the United States or throughout the world, possibly, and that after a while we'll get fewer and fewer people actually wanting to even try to make the leap to come to Canada? We need those doctors so badly.

● (1235)

Dr. Amber McPherson: I wouldn't go so far as to say that Canada is getting a bad reputation. I think everyone understands that bureaucracy comes with paperwork, and—

Helena Konanz: But you said that Canada has a lot more than you—

The Chair: You have 32 seconds.

Dr. Amber McPherson: There certainly is frustration with the process. There's a very large online community of U.S. physicians who explore the options of practising abroad, and—

Helena Konanz: I'm sorry to interrupt you, but we have only a few more seconds.

British Columbia instituted a campaign to try to recruit more U.S. physicians. Do you know if any of your colleagues are looking to move to British Columbia? Is that working? You originally were going to move there, right? Do you feel it's working?

Dr. Amber McPherson: I actually have a couple of colleagues who moved to British Columbia this year.

Helena Konanz: Are they actually working?

Dr. Amber McPherson: Yes.

Helena Konanz: Okay. That's great to hear.

Thank you.

The Chair: Thank you. The time is up.

Mr. Eyolfson, you have six minutes.

Doug Eyolfson: Thank you, Chair.

Thank you all for coming. This is all very useful information.

Dr. McPherson, you talked about a lot of the barriers for immigrants coming in with these trainee programs. You said that this is with the provincial nominee program. Are these spots determined by the provinces?

Dr. Amber McPherson: Yes, I'm referencing provincial nomination. Those are unique to each province. They're basically pathways to express entry to facilitate getting permanent residency. Then there are specific pathways for physicians.

Doug Eyolfson: Thank you.

Dr. Dagenais, you talked about the different programs for different graduates of different countries. You talked about the bridging program. Is each bridging program specific to each province, or is this a unified federal initiative?

Dr. Marie Dagenais: No, the bridging programs depend on the university. They are organized by the university. Not all Canadian faculties of dentistry have them.

Doug Eyolfson: Thank you.

I'm more familiar with medical licensing. Is a dental licence provincial or federal?

Dr. Marie Dagenais: A dental licence is provincial.

Doug Eyolfson: Is there portability or flexibility between provinces with a licence to practise dentistry?

Dr. Marie Dagenais: There is. Our certification exam is required by all provinces. You can be portable between the provinces.

Doug Eyolfson: Let's say I'm a dentist practising in Ontario and I want to practise in Manitoba for a locum. A dental clinic needs coverage for a week. If I wanted to go from Ontario to Manitoba, would I have to apply for a Manitoba licence to do that or would my credentials be recognized to allow me to simply go and work?

Dr. Marie Dagenais: You would have to apply for a licence in Manitoba. Manitoba may have an additional requirement, something like an ethics course. I'm not sure about Manitoba, but it's actually fairly simple to move from province to province.

Doug Eyolfson: Thank you.

I ask this because I find myself in a similar position. My skills are very portable. I have a Royal College certification in emergency medicine that's recognized in any province. Kenora, Ontario, is a two-hour drive west of me. When they are short, I could hop across the border on a week off and do some shifts. However, I'd have to go through all the steps to apply for an Ontario licence to practice.

Do you agree that Canadians would be better served if there were some co-operation and provinces would recognize each other's licences?

● (1240)

Dr. Marie Dagenais: I would agree with you.

Doug Eyolfson: Thank you.

Dr. Irwin, thank you for what you do.

I've worked in emergency medicine. I have worked in a lot of departments that see children and adults. Given the low volume of critically ill children, you can imagine that when a critically ill child rolls in, for those of us who don't see too many children, it is, to say the least, anxiety provoking. I appreciate what you do. You're right. They are not just small adults; they have very unique health care needs.

You were talking about the different countries where pediatric training is considered equivalent. Again, is it the provinces that do that, or is it the federal government?

Dr. Meredith Irwin : Currently, the licensing, the CPSO, which would be—

The Chair: You have one minute.

Dr. Meredith Irwin : —our licensing authority in Ontario, would make that determination. There's currently a different pathway that has just changed for U.S. trainees versus others, and then it depends on where you did which parts of your training.

I would really welcome some collaboration and similarity across provinces, especially in pediatrics where we would love to help, where possible, across provinces when there are critical shortages, as you heard, and in some of the provinces where they can't recruit specialists at all in certain areas.

Doug Eyolfson: Thank you very much.

The Chair: I now go to Madame Larouche.

[*Translation*]

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

Andréanne Larouche: Thank you very much, Madam Chair.

Ms. Dagenais, in one of our previous meetings, we welcomed a dentist who talked about the pressure the new insurance system has created. There's nothing wrong with establishing a system, as long as the public still has access to services. In your opening remarks, you brought up the issue of rural areas.

I got a message from a Sept-Îles resident where dental services are already limited. She said that, while essential for reducing financial barriers, the government's dental care access program isn't suited to isolated communities. There are few participating clinics, and they're overcrowded or located several hours away, making real access to care extremely limited.

First, she says she's covered and has no supplements to pay, but that she can seldom get an appointment.

Second, she says that sometimes, people have to wait several years before they can get an appointment, even for basic care.

Third, she says that people have to travel long distances to reach the clinics, that it's costly, and that it's often incompatible with work or family responsibilities.

Fourth, she says her teeth were needlessly deteriorating, because she can't get regular follow-up appointments.

You talked about labour needs. One of the topics this committee's studying is the question of immigration needs to address the labour shortage in the health care system.

Do you think the government should have looked further into the labour issue before implementing this program and making promises to the public? In the end, the public is disappointed, because we don't have the resources to provide them with the service described in the program.

Dr. Marie Dagenais: I would recommend that governments, professional bodies, universities and organizations like BNED keep working together. That would make it possible to put a plan in place.

Right now, we're receiving a lot of applications and we're administering exams. However, there's no plan for those who pass the exam. They don't know where they'll be working.

We need a plan to make sure rural regions have access to dentists. There are also other disadvantaged groups that need care, such as people with disabilities.

We need a plan to make sure everyone receives proper care.

● (1245)

Andréanne Larouche: In your opening remarks, you also mentioned that those who had passed the exam had to get up to speed, which can take up to two or three years.

Is that right?

Dr. Marie Dagenais: Canadian universities bridging programs for foreign dentists are two to three years long.

Andréanne Larouche: Have you heard from people for whom it's more difficult because they fall in a grey area? They might not have the same resources as others, which can cause issues during that two or three-year wait.

Could tax measures be used to support professionals while they're in school or in the process of getting their degrees accepted?

Dr. Marie Dagenais: Essentially, there should be more spots offered in bridging programs.

In 2024, there were 61 spots available, but the National Dental Examining Board of Canada receives between 1,500 and 1,700 requests a year from foreign dentists who want to write our exam. That means a lot of dentists can't get a spot. Their other option is to complete our equivalency process, which is made up of a series of exams, but the success rate is still low and varies a lot. As I said, results can range from 30% to 95%. Many don't complete the process, and more than half of the candidates have to retake the exam.

More spots should be offered for foreign dentists. We need them, but they need support, so that they can succeed and contribute to the profession.

Andréanne Larouche: Thank you very much.

Dr. Irwin, do you know if SickKids hospital uses interns on internationally funded visas? If so, does it really help meet local needs, knowing most of these students go back home once their training's done? Is that your experience?

[*English*]

Dr. Meredith Irwin : I am part of the University of Toronto, and you previously heard from Dr. Houston. We have a very small subset of the 459 visa trainees she mentioned. You're correct, they do return to their country, but they do not take spots that are available for our Canadian graduates. As you also heard, they are very critical to providing this workforce that is strained right now and expanding our workforce. They definitely do not take the inadequate number of spots that we have currently for pediatric specialty training.

The Chair: Thank you very much.

We're going to go to the second round, which is a five-minute round.

I'll begin with the Conservatives.

Mr. Bailey, you have five minutes, please.

Burton Bailey: Thank you, Mr. Chair.

Dr. Irwin, how many pediatric spots are there across Canada? Is the number under 10?

Dr. Meredith Irwin : That's a great question. That's part of our initiative where we collected the data.

If we look at provincially or publicly funded spots—

Burton Bailey: Yes, domestic—

Dr. Meredith Irwin : —on average, there are around 65 per year for the subspecialties. There are a larger number—I'll have to get you the exact number, but it's at least double that number—for general pediatrics. First, you must do general pediatrics for four years, and then the subspecialties; so that 65 is for that latter part of training.

Burton Bailey: In terms of Ontario, do you know how many extra spots there are for pediatrics in that extra group through the University of Toronto?

Dr. Meredith Irwin : Are you talking about the visa specifically?

Burton Bailey: Yes.

Dr. Meredith Irwin : I do know that for general pediatrics we have about four. Again, it does not take away from the other 20 to 25.

Burton Bailey: I get that.

Of those four, have you ever had a female from Saudi Arabia?

Dr. Meredith Irwin : Yes.

Burton Bailey: How did you deal with the language barrier? Did that work itself out?

Dr. Meredith Irwin : All of our trainees—not just the visa trainees, who are not Canadian medical graduates—take part in what I'll call a probationary type of process, which we have for the first several months. They are not only judged on their medical competency but also on their language competency as part of that.

● (1250)

Burton Bailey: Thank you so much.

Madam Chair, I'd like to share my time with Dan Mazier. Thank you.

The Chair: Mr. Mazier, you have three minutes and 12 seconds.

Dan Mazier: Thank you, Chair.

I'd like to move the following motion:

> That, given that the Chair abruptly suspended the meeting before completing one hour of testimony as agreed by the committee, the committee summon Dr. Patricia Houston, Vice Dean of Medical Education at the University of Toronto, to appear within one week of this motion, for one hour of testimony as part of the study on the Impact of Immigration Policy on Healthcare.

The Chair: There's a motion on the floor.

Ms. Sidhu.

Sonia Sidhu: Madam Chair, I just want to let everyone know that there's a technical difficulty. Two or three times it's happened. It's not anybody's fault. It was a technical difficulty. The second panel was waiting for that.

Everyone has a question for the second panel. It's not anybody's fault. It's a technical difficulty.

The Chair: Thank you.

Ms. Konanz.

Helena Konanz: Yes, I support this motion, and I would like it to go to a vote.

I did not get to ask her any questions. I felt that all of us here were really being educated about the programs that the U of T offers in particular for Saudi Arabian students. I think we were getting to the core of what might be an issue in our medical system here—that we're excluding Canadians and bringing on people from other countries who won't be staying here to work.

I don't know about everyone else around this table, but the people in my riding, in my area, are desperate for these doctors. We can't have people come and train here and then leave the country. If there's room for somebody to be here to train, then there must be room for a Canadian or somebody from another country to train here and then stay here.

They're taking up the space, and I'd like to hear more about it, so I support this motion.

The Chair: Mr. Strauss.

Matt Strauss: Thank you, Chair.

It's a really important issue. The motion that we previously agreed to was that we would do one hour of questions with her. We debated that motion at length. From my point of view, there already procedurally is a motion to that effect. We only got 50 minutes with her. I think the next time she appears it could be by Zoom. There's no reason that it needs to put her out and have fly her back up to Ottawa.

Ultimately, this committee has already agreed that we would have one hour of questioning with her. We didn't get it because of technical difficulties, but we did have resources to continue.

The Chair: Just to clarify, we were 11 minutes short in that hour, so perhaps you would like her to come for 11 minutes.

Matt Strauss: I think if she is going to go through the hassle of reappearing, then 11 minutes seems not....

The Chair: You just suggested a Zoom meeting.

Matt Strauss: Sure. I think that would be reasonable, depending on her schedule.

However, she was giving very interesting answers. I think it's a fundamental issue with our medical education system if we're training up to 20% of doctors at these institutions to not serve Canadians, using Canadian public resources, so yes, I support the motion.

Thanks.

The Chair: Thank you, Mr. Strauss.

Maggie Chi: Can we suspend for a moment, please?

The Chair: We'll suspend.

● (1250)

_____(Pause)_____

● (1310)

The Chair: I call the meeting to order. Let it be known that as a courtesy I'm allowing the Conservative member to have five minutes with the witnesses.

Mr. Strauss.

Matt Strauss: Thank you, Chair.

My questions today are for Dr. McPherson.

Dr. McPherson, thank you so much for coming today, it means a lot. On behalf of the people of Kitchener, thank you for coming to serve our community. Beyond that, thank you for coming to committee today, because you're not just serving Kitchener now, you're serving the whole country of Canada. We're really pleased and proud to have you here.

I'd like to ask some questions at a high degree of granularity because I think individual cases help us to understand what is actually going on with immigration for health care professionals. If I ask you any questions that are prying or you don't feel comfortable answering, just please let me know. Don't feel compelled to answer anything.

We spoke a little bit before the meeting. You've practised in both countries. You've practised all around the United States, as you told me. Is there any reason ER doctors in general in the United States wouldn't be able to practise in Canada tomorrow?

Dr. Amber McPherson : Not that I'm aware of. I haven't found any really significant differences in the practice patterns that would prevent an American physician from practising in Canada.

Matt Strauss: Fantastic.

Overall, when you decided to come to Ontario, what barriers in terms of getting your licence recognized did you meet?

Dr. Amber McPherson : I actually found the CPSO process for licensing to be fairly straightforward, just quite long. I would say that compared to the confusing process of British Columbia, Ontario's CPSO compares favourably.

Matt Strauss: I'm pleased to hear that.

When you say long, how long do you mean?

Dr. Amber McPherson : It took me a few months to get the documents together. A lot of that included getting official copies of transcripts from medical schools, which have to be mailed directly to the CPSO. Those are sort of the rate-limiting steps. If you are really dedicated you can get it done within two or three months.

Matt Strauss: I see.

I won't ask your opinion on this, but I would say that if you hold a licence in Oregon it's probably the case that you passed all your medical school courses. It's a little bit strange to me that they would insist on verifying those documents in particular.

You spoke a little bit about the provincial nominee program and how that was giving you a hard time because of some terminology that I think pretty obviously needs to be changed. May I ask which immigration program you are currently here on and working under?

Dr. Amber McPherson : I'm currently here on a temporary work permit, which will expire after three years.

Matt Strauss: Beyond the provincial nominee program that you're speaking about, are there any other federal immigration programs that you have evaluated or considered that could take you on the path to permanent residency?

Dr. Amber McPherson : I'm not aware of any other pathway that would be viable for me. I am trying to improve my French to get some additional points for my application.

Matt Strauss: Tell me a little bit more about that. How would improving your French improve your ability to buy a home in Kitchener, Ontario?

Dr. Amber McPherson : If I can demonstrate a certain level of French then I can potentially apply for express entry as a French-speaking skilled worker, which is an alternative pathway.

● (1315)

Matt Strauss: If you were to be evaluated and meet criteria to be a French-speaking skilled worker, you would have an easier time achieving permanent residency to work in Kitchener, Ontario, as an emergency room physician?

Dr. Amber McPherson: Yes, it's just essentially a completely different pathway, which I don't think has any specific bearing on being a physician. It's really just any skilled professional who is fluent in French can qualify for an alternative pathway to express entry.

Matt Strauss: I'm honestly a bit flabbergasted by this. Could you tell me which languages other than English you encounter in the emergency room in Kitchener, Ontario, say by frequency?

Dr. Amber McPherson : Quite a few of my patients are Indian and are speaking various language from India. I've had quite a few patients who speak Mandarin and Arabic. I don't think I've had any patients who speak French and not English.

Matt Strauss: I won't ask you to speak to this as you're going through the immigration process, but it seems to me that this could be rationalized in part. If you continue to have difficulty achieving permanent residence status, either through the PNP or any other program, what hardships does this cause you? Does it put you at risk of going back?

Dr. Amber McPherson : The short-term issue is that there's a 25% foreign investor tax on purchasing a home. I'm living in a rental house with my husband and children, which is not a position I've been in for quite some time. It's not ideal. We would like to be able to—

The Chair: Thank you. We've gone 21 seconds over time, Mr. Strauss.

Matt Strauss: Thank you very much.

The Chair: I wish to thank the witnesses for being here. I wish to thank them for giving their time and their expertise to the answers.

I also want to thank the committee for being generous enough to give the Conservatives an extra five minutes for questioning because no one else got that. Thank you for that courtesy.

Dan Mazier: Chair—

Sonia Sidhu: Madam Chair, I move to adjourn the meeting.

The Chair: Yes, the meeting is adjourned.