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Chair: Hedy Fry



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• (1105)

[English]

The Chair (Hon. Hedy Fry (Vancouver Centre, Lib.)): Good morning, everyone. I apologize for being late.

[Translation]

I call this meeting to order.

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

[English]

We recognize that we meet on the unceded territory of the Algonquin Anishinabe peoples.

Today's meeting is taking place in a hybrid format. Most of our witnesses are online. I will have to, for their sake, reread all of the instructions that you know by heart now.

I'd like to remind participants of the following points.

Please wait until I recognize you by name before speaking. For those participating by video conference, click on the microphone icon to activate your mic and please mute yourself when you are not speaking.

At the bottom of your screen, you can select the appropriate channel for interpretation: floor, English or French.

I'll remind you that all comments should be directed through the chair, not directly to the person you wish to speak to.

For members in the room, if you wish to speak, please raise your hand. On Zoom, please use the "raise hand" function.

The clerk and I will manage the speaking order as best we can, based on whose hand we see first. We appreciate your patience and understanding in this matter.

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

I want to welcome our witnesses.

Please note that each witness has five minutes to present. That five minutes is for your organization, so if there are two of you who wish to speak, you're going to have to split your five minutes.

I will give you a one-minute and then a 30-second shout-out when you're coming close to time. People can ask you questions on

some of the points you may not have been allowed to finish; you can elaborate then.

After you've presented, there will be a question and answer session. The questions and answers will be limited in terms of timing: it's not just the questions and then another set of time for answers. I will do the same thing and give you a one-minute and then a 30-second shout-out, so you know how you're doing.

In the first hour of this meeting, from the Canadian Anesthesiologists' Society, we have Vanessa Foran, chief executive officer, and Dr. Giuseppe Fuda, president.

We have the Canadian Association of Schools of Nursing and Dr. Rani Srivastava, president-elect.

We have the Royal College of Physicians and Surgeons of Canada and Dr. Christopher Watling, chief executive officer.

We will start with the Canadian Anesthesiologists' Society.

You have five minutes for your opening remarks.

Vanessa Foran (Chief Executive Officer, Canadian Anesthesiologists' Society): Good morning, Madam Chair and honourable members of the committee.

My name is Vanessa Foran. I am the chief executive officer of the Canadian Anesthesiologists' Society. Today I am joined by Dr. Giuseppe Fuda, president of CAS and a practising anesthesiologist in Montreal.

The Canadian Anesthesiologists' Society, CAS, is the national voice of anesthesiology in Canada and is a not-for-profit, volunteer-led organization focused on advocacy, education and research. We represent more than 2,500 health care professionals across the country. Our members include anesthesiologists, family physician anaesthetists, medical residents and anaesthesia assistants—all united by a commitment to delivering safe, high-quality perioperative care for patients across Canada.

Many people are not aware that post-operative mortality within 30 days is the third leading cause of death in the world, after cancer and cardiovascular disease. Your anesthesiologist is there to reduce the risk. They're your guardian angel at one of the most vulnerable times of your life. Our members are physicians who keep you safe before, during and after surgery. They are monitoring every heart-beat, every breath and every vital sign, and leading resuscitation when complications occur.

Anaesthesiologists also provide care beyond the operating room in critical care, labour and delivery, emergency medicine, and acute and chronic pain management. They are increasingly involved in procedures outside of the O.R., such as interventional radiology and procedural sedation.

We sincerely thank you for the opportunity to contribute to your study of the impact of immigration policy and barriers to integrating internationally trained professionals.

I will now hand this over to Dr. Fuda.

Dr. Giuseppe Fuda (président, Société canadienne des anesthésiologistes): Thank you, Madam Chair.

Canada is facing a serious anaesthesia workforce shortage at the moment, one that contributes to surgical backlogs and reduces access to care.

[Translation]

That worker shortage affects not only anesthesiologists, but also the nurses, respiratory therapists and anesthesia assistants who work in our operating rooms.

[English]

We have only about nine physician anaesthesia providers per 100,000 Canadians, which is well below countries such as Germany, Australia and the U.S. This shortfall is compounded by an aging workforce, burnout and extended responsibilities outside the operating room.

To ensure that patients continue to receive timely surgical care, both short- and long-term solutions are needed. These were outlined in our 2023 HR resources position statement, and they include a significant increase in anesthesiology residency positions, recognition of health care workers' credentials between hospitals, regions and provinces to allow flexible redeployment where needed, redirection of select surgeries to underutilized centres, expansion of anaesthesia training programs to better support anesthesiologists, support for physician well-being, and retention and analysis of institution-specific efficiencies.

One key opportunity directly relevant to your study is simplifying and accelerating the licensing of internationally trained anesthesiologists while maintaining an unwavering commitment to patient safety. Currently, pathways for internationally trained physicians are fragmented and inconsistent across provinces. For example, the Royal College approved jurisdictions route recognizes training from only four international certifying bodies, leaving most qualified anesthesiologists to navigate complex, lengthy and costly equivalency assessments.

• (1110)

[Translation]

It's important to take into account that the quality and duration of medical training varies significantly from country to country, which complicates skills assessment.

[English]

A particularly restrictive barrier is the recency-of-practice requirement. Physicians who immigrate to Canada often lose licensure eligibility because they cannot maintain an active practice abroad while waiting for accreditation here. In some provinces, they must even return overseas for a month at a time to preserve their eligibility.

[Translation]

That's an unrealistic requirement for newcomers and their families.

[English]

We believe that Canada can do better. The European Union provides a useful model. Physicians trained in approved jurisdictions with harmonized standards are recognized automatically within four months. When training gaps exist, it provides an adaptation period or targeted assessments to ensure safety and fairness. Language proficiency, professional conduct and continuous quality assurance are all verified.

[Translation]

To sum up, the Canadian Anesthesiologists' Society recommends establishing a transparent, time-limited process for foreign-trained anesthesiologists; modernizing recency of practice rules to reflect the realities of immigration; and enabling a harmonized process for medical science licensure recognition for all provinces and territories.

[English]

Thank you.

The Chair: Thank you very much.

I will now go to the Canadian Association of Schools of Nursing.

Dr. Srivastava, president-elect, you have five minutes.

Rani Srivastava (President-Elect, Canadian Association of Schools of Nursing): Good morning.

My name is Dr. Rani Srivastava. I am the president-elect of the board of directors of the Canadian Association of Schools of Nursing, CASN. I also currently serve as dean of nursing at Thompson Rivers University in British Columbia. I have previously worked in roles in practice as vice-president and chief nursing executive. I am not an internationally educated nurse, IEN, but I have worked closely with IENs in practice and education.

The Canadian Association of Schools of Nursing is the national voice for nursing education in Canada, representing 93 member institutions across the country. CASN supports the education of registered nurses, registered psychiatric nurses and nurse practitioners. We commend the House of Commons Standing Committee on Health for undertaking this important study on the integration of IENs. The motion introduced by MP Dan Mazier addresses a critical issue: Canada is facing a nursing workforce crisis. Over the past five years, nursing vacancies have tripled. We have significant challenges in both recruitment and retention. Data from a pan-Canadian survey indicates that four in 10 nurses report that they intend to leave their job—or the profession—or retire within the next year. The impact is significant on the professionals, the quality of care and patient safety.

Internationally educated nurses who choose to migrate to Canada are an invaluable and grossly underutilized resource. We must remove unnecessary bureaucratic barriers for licensure. Internationally educated nurses emigrate to Canada from all over the world. There are variations in education, professional nursing culture and expectations. They have different health care system experience.

The two main barriers faced by IENs are regulatory complexity and workplace integration challenges. Regulatory bodies work to ensure public safety through a rigorous process of credentials recognition. For IENs to be part of a sustained solution, CASN recommends focused attention in three areas: streamlining the registration process, pairing that with quality bridging education, and workplace integration support for both short-term and long-term success. Collectively, we must adopt a coordinated, evidence-informed and ethical approach. Streamlining and harmonizing the registration is already happening. In response to the pandemic and the exacerbation of long-standing nursing shortages, nursing regulatory bodies have collaborated with governments, employers and professional associations.

A recent scan of 20 nursing regulatory bodies across Canada found that while licensure requirements are broadly consistent across jurisdictions, notable differences exist in the pathways, particularly in recency of practice requirements and expedited pathways for internationally educated nurses, leading to inconsistencies and inequities in licensure pathways and creating unnecessary complexity. There is a need to further explore the harmonization and consistency of pathways. This requires commitment. We know that competency assessment is important, but it often becomes the bottleneck. Partnerships between regulators and post-secondary educators can be hugely beneficial.

CASN also asks for an establishment of a joint commission between the Canadian council of nurse regulators, CASN, CNA and employers to ensure alignment between the needs and strengths of all the stakeholders.

Lastly, we ask for the exploration of international partnerships, including Canadian accreditation of international schools and IEN residency structures to reduce this redundancy and accelerate licensure.

Ensuring quality bridging education is the second piece. These are important tools that can support not just entry to practice but also successful integration in both the long term and the short term. These programs require the ability to accommodate the unique needs and experiences of IEN learners through responsive pedagogy and flexible learning-centred programming that is practice-oriented. The ability to provide responsive and effective bridging education hinges on increased sustainable funding of public educational institutions. National standards for bridging education and an accreditation program will ensure the quality of bridging education.

The third prong is to provide practice support for both short-term and long-term integration. This requires commitment and partnership between the IENs entering the workforce and the existing professionals in the system. Employers need to support both, recognizing the needs of both parties.

● (1115)

The Chair: Please wrap up.

Rani Srivastava: CASN's internationally educated nurses mentorship program provides examples of where such support can be provided.

To summarize, the world is facing a global nursing shortage. Canada must act now to support the IEN integration that should be seen as a key pillar of a broader HR strategy for nursing. That includes strengthening Canadian nursing education and the integration of IENs.

Thank you.

The Chair: Thank you very much.

Now I go to the final witness from the Royal College of Physicians and Surgeons of Canada, Dr. Christopher Watling.

You have five minutes.

Dr. Christopher Watling (Chief Executive Officer, Royal College of Physicians and Surgeons of Canada): Thank you very much.

Good morning, everybody.

My name is Chris Watling. I'm a neurologist, and I am the chief executive officer of the Royal College of Physicians and Surgeons of Canada. I'm speaking to you today from the ancestral territory of the Anishinabe, Haudenosaunee, Lūnaapēwak and Chonnonton Nations, from London, Ontario.

I will share a little bit about the Royal College. We are a national, not-for-profit organization that represents over 50,000 specialist physicians and surgeons across over 100 different disciplines in Canada and around the world. We're the voice of specialty medicine in Canada, and we set the standards for specialty medical education, assessment and lifelong learning. We also do what we can to promote sound health policy.

In that vein, I'm very grateful for this opportunity today to highlight some of the challenges that internationally trained specialist physicians face when they move to Canada and try to integrate into our health care workforce. Estimates vary, but we think there may be as many as 13,000 internationally trained physicians in Canada who are not in practice. Internationally trained physicians have identified that the process to becoming a practising physician in Canada is challenging, time-consuming and often confusing.

The government has, thus far, very appropriately focused on getting internationally trained primary care physicians and family doctors into practice. We agree with that at the Royal College, but we also want to point out that optimizing the Canadian health care workforce requires attention to both primary and specialty care, because they are interdependent.

I'm just going to identify, first, some of the various routes to getting to be a certified specialist physician in Canada, and some of the specific areas that we might be able to improve, or have already improved. Internationally trained physicians who have not yet completed residency or postgraduate training or who are willing to re-train in Canada have the option of matching into a Canadian residency training program through the Canadian residency matching service. Related to this route, the Royal College encourages the government to ensure there remains equitable access for all eligible international medical graduates, IMGs, to that match process, to best meet the needs of the system.

Second, internationally trained physicians who already completed residency training and practised abroad in their specialty may complete a practice-ready assessment. This pathway consists of a clinical workplace-based assessment usually lasting around 12 weeks. There are currently nine provinces that offer these, but only three offer them for specialist physicians. Those are Alberta, Manitoba and Quebec.

Third, internationally trained physicians who have completed residency training abroad in a recognized specialty and whose residency training is quite similar to that which would occur in Canada may also use what we call the practice eligibility route. That requires them to take an examination and to complete two years of observed practice in Canada. We've had great support from a grant from the federal government and have had some success in simplifying and streamlining this pathway. We've seen applications increase 400% and processing times drop from several months to several weeks.

Then, finally, we have specific routes for U.S. trainees and those from other approved jurisdictions where training is recognized as a substantial equivalent to Royal College training. These trainees can apply directly to take a Royal College exam. Once they pass that exam, they would be certified without requiring observed practice time in Canada.

What more can be done? First, we think that the practice-ready assessment route is underused and has the potential to expand. It is a quicker and more cost-efficient way of licensing internationally trained physicians compared to a typical residency program, which can last two to six years. We'd encourage the government to consider developing a federal program that supports an expansion of practice-ready assessments for both family doctors and specialist physicians.

Second, we think more can be done to address the challenge of internationally trained physicians in Canada who are just missing a handful of competencies that would be required to meet the full scope of a Canadian credential. We'd encourage the government to consider a funding pool that could help medical schools to provide top-up training to those physicians, which would allow them to more quickly transition—

• (1120)

The Chair: You have 45 seconds.

Dr. Christopher Watling: —into practice.

Third, we think we can do more to support the additional learning that internationally trained physicians require to bridge cultural competency and learning gaps. For example, regardless of where you've trained, if it's outside Canada, you likely lack information about indigenous health and indigenous cultural competency. We would encourage making that training a requirement for all physicians trained internationally, and we're happy to work on that with the government.

Finally, I'll just point out that we've done a lot of consulting with internationally trained physicians this summer, and many of them pointed out that labour market assessments are a major pain point in their process of getting into Canada.

Now is the time, we think, for everyone in the health care system to consider alternative solutions to streamline the immigration and licensing processes for internationally trained physicians so that they can enter the system more efficiently and provide necessary care.

Thank you very much.

The Chair: Thank you very much.

I'll begin the question and answer round. Just to remind everyone, this is a six-minute round. Six minutes are for questions and answers. I'm going to give a one minute and thirty second count to those who are questioning and to those who are answering. You will always have an opportunity in another round to finish off what you were saying.

I'll begin with Mr. Mazier for six minutes, please.

Dan Mazier (Riding Mountain, CPC): Thank you, Chair, and thank you to the witnesses for coming here this morning.

Dr. Watling, does the Royal College of Physicians and Surgeons of Canada support national or pan-Canadian licensure so that doctors can work across provinces and territories without barriers?

• (1125)

Dr. Christopher Watling : We do.

Dan Mazier: Dr. Fuda, does the Canadian Anesthesiologists' Society support national or pan-Canadian licensure so that doctors can work across provinces and territories without barriers?

Dr. Giuseppe Fuda: We do support it, and it's already part of our physician statements. I will go further and say that the Atlantic provinces actually already have the licensure for Atlantic Canada. One thing that's particular to anesthesiologists—

Dan Mazier: Thank you. You do support it, and that's great.

Dr. Watling, does the College of Physicians and Surgeons of Canada agree that population growth is one of the factors impacting Canada's health care system, yes or no?

Dr. Christopher Watling: Yes.

Dan Mazier: Immigration is a form of population growth, then. Is that correct?

Dr. Christopher Watling: Population grows in a variety of ways, including immigration, yes.

Dan Mazier: Dr. Watling, how many members are there in the Royal College of Physicians and Surgeons of Canada?

Dr. Christopher Watling: There are roughly 50,000.

Dan Mazier: Did the federal immigration department consult with the Royal College of Physicians and Surgeons of Canada on this year's federal immigration levels plan, yes or no?

Dr. Christopher Watling: No.

Dan Mazier: According to this year's immigration levels plan, the federal government is planning to allow 395,000 permanent residents and 673,000 non-permanent residents into Canada this year. Will all these individuals be able to get a family doctor this year, if they want one?

Dr. Christopher Watling: I think we have a lot of evidence that Canadians lack family doctors quite significantly. You'll hear more from colleagues at The College of Family Physicians of Canada in the next hour, I think.

Dan Mazier: These individuals will have to go to emergency rooms to see doctors because they won't have access to a family doctor. Is that probably fair to say?

Dr. Christopher Watling: Well, I think maybe that diminishes efforts that are going on across the country to try to improve access to family physicians and to specialist physicians. There is certainly hope that the situation is improving as a result of some of the work that is already under way.

Dan Mazier: Dr. Watling, earlier this month, the Minister of Health stated, "Right now, there's no alignment on immigration and the need for doctors". Do you agree that there is a disconnect between immigration policy and health care capacity?

Dr. Christopher Watling: I am not sure that I have the expertise to speak about immigration policy. I think there are a lot of things driving that, which are not exclusively related to health care.

Dan Mazier: We just talked about Canadians not having family doctors—6.5 million Canadians don't have a family doctor right now. There are lineups in emergency rooms, and we just heard that 395,000 permanent residents and 673,000 immigrants—almost a

million more people—are coming into the system. You have not been consulted. Do you think there's a disconnect?

Dr. Christopher Watling: I think it would be nice to see a stronger link between these things, yes.

Dan Mazier: The Globe and Mail reported this month:

On Tuesday, when Health Minister Marjorie Michel was asked if she would introduce something similar to Bill C-5, which removed barriers for interprovincial labour movement but not for physicians and other health professionals, she said yes.

Is this type of legislation something the college would support?

Dr. Christopher Watling: Sorry, the legislation that you're talking about is to improve interprovincial movement of physicians. Is that right?

Dan Mazier: Yes.

Dr. Christopher Watling: Yes, we're very supportive of that and I think it links to that issue around pan-Canadian licensure.

Dan Mazier: I thought it was important too but the Globe and Mail article went on to say:

However, on Wednesday, Ms. Michel's director of communications, Guillaume Bertrand, clarified that Ms. Michel misunderstood the question and that the government won't be tabling legislation on the issue.

Does that concern you?

Dr. Christopher Watling: I had felt similarly optimistic when I saw the initial comments so it disappoints me.

Dan Mazier: How many internationally trained physicians are currently in Canada but not working as doctors?

• (1130)

Dr. Christopher Watling: I don't think anybody knows, to be exact. We've guessed at around 13,000.

Dan Mazier: You don't think anybody knows? You've never seen any numbers, any reports?

Dr. Christopher Watling: I think it is just difficult information to come by and we've seen numbers but they vary quite widely, so 13,000 is a reasonable number but it's hard to know if it's accurate.

Dan Mazier: Matt, did you want to get in here?

Matt Strauss (Kitchener South—Hespeler, CPC): Sure, I'll start with some questions for Dr. Fuda.

Thank you for being here.

I think we all agree that Canada is currently short on anesthesiologists. I was wondering if your society has hard numbers on that. How many anesthesiologists are we short?

Dr. Giuseppe Fuda: That's a good question. It varies very much geographically speaking. Some provinces are hit more than others. Right now the shortage is much more dire in Ontario—

The Chair: I will allow this answer and then we've run out of time.

Dr. Giuseppe Fuda: —but we don't have a specific number.

The Chair: We now go to Mr. Eyolfson of the Liberals.

You have six minutes.

Doug Eyolfson (Winnipeg West, Lib.): Thank you, Chair. Thank you, all, for coming.

Dr. Fuda, thank you for your comments. My wife is an anaesthetist so I've heard her say many of the same things that you have said regarding shortages of anaesthetists and how this will often cause cases to be cancelled and care delayed.

We've talked about accelerating the training of these international graduates. We know that there's always been a difficulty in coordinating between the federal government and the provinces. What role do you see the federal government playing in that? How can we help facilitate this within the provinces?

Dr. Giuseppe Fuda: That's a very good question. Definitely I think that one issue is that we need the resources to be able to evaluate some of these people, so sometimes this is an issue as you actually need to pay these individuals or these professionals to be able to do proper evaluations. I'm sure Dr. Watling can attest to that.

Definitely that's one thing. In terms of immigration policies as well, like we said, one issue right now is that doctors who are in Canada presently, if they don't work within a certain time frame, are actually not eligible any more. I think that they should try to speak with each other in the provinces about pathways for these people to still become eligible despite the fact that they may not have practised for 18 or 24 months or sometimes even longer. We need to see how we can bridge that gap and have these people actually practise rather than sometimes doing jobs that are completely unrelated to their initial training.

Doug Eyolfson: Absolutely. Would a federal policy help, saying that these evaluations should be done within a certain length of time?

Dr. Giuseppe Fuda: I think it would be good if there was a way for these people to...because they get lost also in paperwork and face other challenges. There has to be some sort of streamlined way for these individuals, these doctors, to be able to go through a pathway and apply, and like you said, have a certain time frame within which they should be able to get an answer on whether or not they can pursue their career.

Doug Eyolfson: Thank you.

To the Schools of Nursing, thank you for your testimony.

We talked about failure of retention. What would you say is the one reason for failure of retention for these nurses who are here and are no longer practising?

Rani Srivastava: I think there are multiple reasons. The retention has to do with both the domestically educated nurses and the IENs. The workforce shortage, the stresses of the employment system and the lack of support all contribute. The specifics will vary from province to province, specialty areas and particular practice settings, but those are, in general, what are cited as the challenges that nurses are experiencing.

Doug Eyolfson: Thank you.

Are you aware of any barriers that these new internationally trained nurses have from an immigration point of view? Are they having trouble getting visas? Are they having trouble getting citizenship?

Rani Srivastava: I do not have information on that. I apologize.

Doug Eyolfson: All right. Thank you.

Mr. Watling, I am a graduate of the Royal College program in emergency medicine and have served on the committee of examiners. I am well familiar with your organization's work.

I'm sure you know the answer to this, but for the committee, the certification of the Royal College is recognized nationally. Is that correct?

• (1135)

Dr. Christopher Watling: Yes, it is.

Doug Eyolfson: I have a Royal College certification in emergency medicine, and I have that certification in any province in Canada.

Dr. Christopher Watling: Correct.

Doug Eyolfson: For specialty physicians, has your organization had any outreach with provincial licensing bodies? When someone is certified by the Royal College, the Royal College is basically giving the stamp of approval and is saying that this individual is now qualified to practise in this surgery, whether it is psychiatry, surgery or emergency medicine.

Is there any talk or any strategy to basically communicate with the provincial licensing bodies to say that we have determined that this person is safe to practise this specialty and we grant a licence to practise that specialty in that province or any province?

Dr. Christopher Watling: Yes. We communicate closely and regularly with the provincial licensing bodies and confirm people's credentials.

Doug Eyolfson: All right, but what I mean is that when they apply for a licence, there is still a process in each province. They have to get the licence.

Dr. Christopher Watling: Yes, that's right.

Doug Eyolfson: Is there any talk about basically shortcutting that process to say that we have the competency and ask, "Can you give this person a licence?"

Dr. Christopher Watling: Yes, we would love to see the Royal College certification just be recognized nationally as the gold standard and simplify that process, because right now people have to apply separately in each jurisdiction, with the exception of the Atlantic issue that Dr. Fuda referenced.

The Chair: Thank you very much.

We will now go to Monsieur Thériault.

You have six minutes.

[*Translation*]

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

I thank the witnesses.

I would like to continue discussing accreditation.

Mr. Watling, how would you describe your collaboration with other colleges that provide accreditation? Can that process really be more efficient?

For example, is the college of physicians more or less strict than you with respect to accreditation?

How would harmonizing accreditation improve efficiency?

[English]

Dr. Christopher Watling: By “accreditation”, are you referring to the licensing process for physicians or to the process of...? We think of accreditation as being related to the quality of training programs, but are you talking about individual physicians?

[Translation]

Luc Thériault: Yes, I'm talking about licensing and equivalency.

[English]

Dr. Christopher Watling: As was already said, Royal College certification is recognized by every provincial and territorial licensing body in the country. Are there opportunities to smooth out and streamline the process of licensing? I would suspect absolutely, yes. We're not a licensing body, although we have regular conversations about trying to share credentialing information to make this as easy as possible.

I think you'll also want to ask this of the Federation of Medical Regulatory Authorities representative who comes in next.

[Translation]

Luc Thériault: Thank you, Mr. Watling.

Dr. Fuda, earlier you said there are nine anesthesiologists per 100,000 Canadians. What would the ideal ratio be?

Dr. Giuseppe Fuda: That depends on the country and the care structure. In some places, there are assistants, so it's hard to compare systems. Regardless, we would probably need 25% to 30% more anesthesiologists to make our system more robust and reliable. That would enable us to provide more services and reduce pressure on anesthesiologists, many of whom work too much not because they want to, but because they have to.

• (1140)

Luc Thériault: You are managing to meet the needs, but, as I understand it, you work a whole lot of hours, which shouldn't be the case.

Dr. Giuseppe Fuda: Right. I have a colleague in Saskatchewan who regularly puts in 90 hours a week. People can do that for two or three years at the start of their career when they have a mortgage to pay off, but it's not sustainable in the long term.

We are struggling to keep the system afloat, unfortunately. Not only are we trying to compensate for these shortages, but we're also neglecting practices that might interest us more, especially outside the operating room, because we simply don't have the resources to do more. For example, we often provide assistance in interventional radiology or scoping to perform sedation, but we are forced to set those practices aside to focus on the essentials of our work. If we

had more resources, we could do something about this problem and people could get a bit of a break.

Luc Thériault: More resources means more money to pay for those resources.

In light of the federal government's new health transfer fund worth \$4.6 billion over 10 years, do you think there needs to be a corresponding substantial increase in our capacity to hire people? That's what we're talking about today. Those people have to be hired, after all.

My question is for Dr. Fuda and Dr. Watling.

Dr. Giuseppe Fuda: I'm not an accountant. I can't tell you if the amount you're talking about is too much or not enough.

[English]

The Chair: You have one minute.

[Translation]

Luc Thériault: What do you think, Dr. Watling?

[English]

Dr. Christopher Watling: I think there is a range of ways to get more people into practice. I think one of the key areas with regard to internationally trained specialists is getting them much more quickly assessed for their readiness to practise, topping up things they're missing and being able to move them into practice quickly that way.

Yes, that will require some additional investment, and I think targeted investment around assessments that is faster, more efficient and standardized nationally would be worthwhile.

The Chair: Monsieur Thériault, you have 13 seconds.

[Translation]

Luc Thériault: Madam Chair, your interventions are kind of confusing. I thought my time was up.

[English]

The Chair: Please go ahead.

[Translation]

Luc Thériault: I actually wanted to pick up on an interesting point that Ms. Srivastava raised. She talked about the problem of recruitment and retention.

Does the retention problem have to do with more than just working conditions? Does it also have to do with our ability to integrate foreign-trained health professionals? Is there an integration problem in this field?

[English]

The Chair: Perhaps, Doctor, you can answer that in another round because we've gone well over time now. Thank you very much.

I now go to the second round. I'd like to explain this round. It's a round of five minutes. There will be five minutes for the Conservatives and the Liberals and the Bloc Québécois will have 2.5 minutes.

I'll begin with Mr. Strauss, for the Conservatives. You have five minutes.

Matt Strauss: Thank you, Chair.

Dr. Fuda, you didn't have a hard number for how many anaesthetists we are short. Do you have a qualitative sense? Is it severe? Is it terrible? Is it outstanding, or is it a moderate shortage of anesthesiologists by your lights right now?

Dr. Giuseppe Fuda: I would say that it was a lot worse three years ago, but now, as medical faculties have increased residency positions and more IMGs have been hired across the country, we are now probably in a moderate stage, I would say. It's not as dire as it was a few years ago.

Matt Strauss: Do you have a sense of how many anesthesiologists are currently being trained in Canada? From the CaRMS matching data, I would estimate about 600. Is that about your view?

• (1145)

Dr. Giuseppe Fuda: You probably know the hard numbers better than I do, so I would agree with you if you've seen it.

Matt Strauss: Perfect, thanks for that.

I have another report from CAPER, that's the Canadian Post-M.D. Education Registry. It indicates that 187 anaesthesia residents currently are visa trainees, usually from another country. The majority of those are from Saudi Arabia or other gulf dictatorships. Does that number sound about right to you?

Dr. Giuseppe Fuda: It sounds about right. It's definitely possible.

Matt Strauss: Is it your understanding that such visa trainees, who are sponsored by gulf states, generally return to their home countries, either because they have a return of service agreement or because of personal preference?

Dr. Giuseppe Fuda: I would say that a vast majority of them do return to their own countries or definitely leave Canada after their training.

Matt Strauss: I guess I will say, on background, that it's very common for members of this committee, and even all MPs in this House, to be contacted by Canadian citizens who did med school in Ireland, Australia, the Caribbean, the U.K. or the United States, who are just desperate to get a residency here. From your point of view, is there any reason that these Canadian graduates of other internationally trained medical schools couldn't use those 187 spots currently used by citizens of Saudi Arabia and other gulf states?

Dr. Giuseppe Fuda: That's an interesting question. I'm not too sure they would take the same spots because the Saudi Arabians are not part of the CaRMS spots. They are add-ons to the normal numbers, so you're basically talking about different pools here.

If you have someone with training from Ireland, you actually would have to integrate the normal CaRMS pathway in those numbers.

Matt Strauss: Yes. It seems to me that if the Kingdom of Saudi Arabia, which is as far as I'm aware a theocratic dictatorship, is willing to pay your way through medical training in Canada, then you get special treatment, but our own Canadian citizens who are training in Ireland cannot receive such special treatment. Is that correct?

Dr. Giuseppe Fuda: I don't know if it's correct in the sense that these IMGs are also eligible to apply to CaRMS, just like every other Canadian candidate—unless I'm wrong, Dr. Watling. It is my impression that they are eligible, especially coming from Ireland. There are four different countries from which they can apply directly, but as an IMG, so there are IMG-specific spots available through CaRMS.

Matt Strauss: Right, but they're not able to avail themselves of this special “paid for by the Saudi Arabian government” pathway. I guess that's what I'd argue is a crying shame.

On a bit of a different topic—

Dr. Giuseppe Fuda: I'll be the devil's advocate. They do have more means to go study in those places, very often at a very high price, and not every Canadian has the opportunity to do that, so that's something to keep in mind as well.

Matt Strauss: Yes, but I think our concern is getting enough anaesthetists into Canadian ORs. If we're training folks who are then going back to Saudi Arabia, it's hard to see how our medical education system is serving the needs of the Canadian public.

On a bit of a different topic, my colleague asked some questions of Dr. Watling about whether the immigration ministry had consulted the Royal College of Physicians and Surgeons about whether we're able to take in the numbers that are coming in. Has the immigration ministry consulted with the Canadian Anesthesiologists' Society about that same question?

Dr. Giuseppe Fuda: No, it has not.

Matt Strauss: That seems like another crying shame.

Dr. Watling, I'm also a fellow of the royal college. It is my understanding that the vast majority of physicians in this country who write the royal college exam have access to the old questions. Is that your understanding?

Dr. Christopher Watling: It is not my understanding that most have access to old questions. I think anyone trained in a Canadian program has access to a lot of supports to be able to prepare them well for exams, because in a lot of ways Canadian programs are really geared for that.

Matt Strauss: I would characterize it as an open secret. I think everyone knows that Canadian trainees have access to the old questions. It is also my understanding that for most specialities, every year's exam is largely comprised of the old questions. Is that your understanding?

Dr. Christopher Watling: No. That is incorrect.

The Chair: Thank you, Mr. Strauss. I'm sorry. You've gone over your time now.

We'll move to the next round.

Mr. Powlowski, you have five minutes, please.

Marcus Powlowski (Thunder Bay—Rainy River, Lib.): First of all, let me say that I'm somewhat disappointed by some of these Conservative questions, which are using this study as a forum to suggest or to say that the number of immigrants is causing a crisis within our health care system.

As somebody who continues to work, at least a little bit, in the health care system, I can say that most of the immigrants are young. They're not people who require CT scans, MRIs, colonoscopies, surgeries or ICUs, so they are not a big burden on the health care system. On the other hand, if you go to the hospitals, you'll be looked after by a nurse who's an immigrant. You'll be looked after by a doctor who's an immigrant. If you have elderly parents and they go to an old folks' home, they'll be looked after by PSWs who are overwhelmingly immigrants. My rant on that is now over.

Dr. Watling, you talked about PRAs, practice-ready assessments, being underutilized. You suggested that there ought to be a federal program to expand this. Could you expand on this a little bit? How many physician specialist positions are there a year that come through the PRA process in Canada?

• (1150)

Dr. Christopher Watling: I don't actually know, because provincial regulators in a few provinces run PRA processes, and when people succeed in them, they go directly to licensure. I would say that the majority of those people who are specialists don't come to the royal college. We see some people, probably only about 50 or fewer a year, who use that PRA as exam eligibility to then get them to full fellowship with the royal college, but most PRAs actually operate a little bit outside our viewpoint.

The expansion of it that I see as possible relates to opportunities to create some national standards, particularly around PRAs for specialty medicine. There are some really good programs looking at PRAs for family medicine, especially in Nova Scotia and Alberta, but I think we can do more around the specialty area. I think we'd love to be engaged in helping to develop national standards and national assessment tools and being able to get people assessed in about a 12-week period as opposed to the much longer one.

Marcus Powlowski: We know that you have only a very brief time here. However, you can submit something in writing. Specific recommendations on how we as the federal government can help get more people through the PRA process would certainly be welcome.

Dr. Christopher Watling: Thank you.

Marcus Powlowski: On a second topic, you talked about top-up training. I think that's really important. I've worked in many countries as a physician. The quality of graduates from different countries will vary quite a bit. Rather than making everyone go back to medical school to do it all over again, some people may need only months and some people perhaps a year or two.

Which provinces are doing a good job in terms of that top-up training? It would seem to me that this is really underutilized.

Dr. Christopher Watling: I think it is really underutilized. If I have this right, I think Manitoba is doing a fairly good job of this at the moment. I'm not aware of other programs systematically looking at that, but I think there's a huge opportunity there: You have 80% of what you require. Let us fill in the gaps. In six to 12 months, you'll be ready to go.

That would be much more efficient than telling someone to apply for a residency program.

Marcus Powlowski: We'll make recommendations coming out of this study. Maybe I could ask everyone around the table about the top-up training. Should we be doing the same in nursing and the same in anaesthesia? Should there be more programs for top-up training that would bridge the gap and get people into the system quicker?

Maybe I can ask both the anaesthesia people and the nursing school people about that.

Dr. Giuseppe Fuda: Yes, I think it could be a great opportunity. We also need a robust way to evaluate the baseline and evaluate whether they need 20%, 30% or 40%. This is where it gets tricky. It's trying to establish that as well. There we would need to partner with universities and programs to be able to do that. This is often where the roadblock is.

Rani Srivastava: I would agree. The practice-ready assessment—the competency assessment—is really important. As Dr. Fuda said, a partnership between education institutions and regulatory bodies would be hugely beneficial and efficient there. That forms the basis for the second piece, which is the top-up training that Dr. Watling so nicely articulated.

You need to have a baseline assessment and then determine what percentage and what kind of training is needed. It is not one-size-fits-all, where everybody goes into the same pathway.

The Chair: Thank you very much. That ends your time, Mr. Powlowski.

I will now go to Monsieur Thériault for two and a half minutes please.

[Translation]

Luc Thériault: Thank you, Madam Chair.

I've been listening to all the questions and answers. The worker shortage issue doesn't go back just five or 10 years. It's been going on for at least 20 years. After all these years, why haven't issues around co-operation among various professional associations been resolved? What factors are getting in the way of professional associations' ability to communicate with each other and exchange best practices, always within their areas of jurisdiction, of course? One does not preclude the other. It's been 20 years, and they still haven't managed to do that. Why?

What are your thoughts, Mr. Watling?

• (1155)

[English]

The Chair: I think you may have to direct your answer specifically. It seems no one has the answer, Monsieur Thériault.

[Translation]

Luc Thériault: I asked Dr. Watling to answer my question. I don't know if he heard the interpretation.

[English]

Dr. Christopher Watling: I may just say that I agree with you. I share that frustration.

I sense at the moment, at least among different medical organizations in Canada—The College of Family Physicians and the Federation of Medical Regulatory Authorities—a much greater will to co-operate than we have perhaps seen in the past. I think perhaps some of the historic territoriality is going away. There's a real desire on our part to work collectively rather than separately.

I feel more optimistic about the next five years than perhaps the last 20 years would suggest.

[Translation]

Luc Thériault: Do you think there might be some kind of corporatism that's getting in the way of accelerating the credential recognition process?

[English]

Dr. Christopher Watling: I'm not sure. For me, the biggest thing that has been a barrier, particularly with 70-odd specialty disciplines, is a lack of nationally coordinated planning and numbers to help us.

You've already seen, when you ask for data, how challenging it is for us to put forward exact data. I think the thing that would really have driven things forward is nationally endorsed and agreed-upon planning platforms.

The Chair: Thank you very much.

I now move to Madam Konanz. You have five minutes.

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

Dr. Srivastava, in 2022, your organization appeared before this committee and your executive director, Cynthia Baker, said that “In terms of international education, this has...to do with the regulatory bodies that license the internationally educated nurses. The process is slow. There is an evaluation process that is time-consuming.”

Where do these processes stand today?

Rani Srivastava: As Dr. Watling has said, there's better co-operation, but that certainly is still an area where there's considerable backlog.

Every province does the practice assessment. The regulatory bodies do the practice assessment and then make recommendations around how much of a top-up or further competency support is needed, or what kind of bridging program—

Helena Konanz: Excuse me. Would you consider it to be still too slow?

Rani Srivastava: There is a lot of room for improvement. Yes, I would agree.

Helena Konanz: Okay.

In the same meeting, Dr. Baker suggested a “more standardized, one-year program across the country for internationally educated nurses so that they can be moving along with the process.”

Is that still the position of the Canadian Association of Schools of Nursing?

Rani Srivastava: I think CASN would advocate for a more personalized approach. Some people will need a year, some people may need less and some people may need focused attention in different areas.

Helena Konanz: Would you say that a more standardized program across the country is needed?

Rani Srivastava: I think that standardized programs are needed that allow for variations based on the member's practice assessment.

Helena Konanz: Okay, so, there should be a standardized program across the country.

A CIHI report entitled “The state of the health workforce in Canada, 2022” found a shortage of 60,000 registered nurses. That's really no surprise to rural communities, like those in my riding.

Do these numbers sound accurate to you? That was 2022. Do you feel that they might deepen, or do they sound accurate to you?

• (1200)

Rani Srivastava: They sound accurate. I think the situation is a little bit better—just anecdotally, from looking at where our graduates are going and at, in general, the gaps that exist in the practice areas across the system. The nursing shortage has gotten a little bit better, but there's still a lot of room for improvement.

Helena Konanz: Again, with regard to that nursing workforce crisis, you mentioned that there's a failure of retention for all nurses. Can you explain that? Where do those who aren't retiring go?

Rani Srivastava: Sometimes people leave that workforce to go to a different practice setting. Sometimes they leave the profession altogether and do something different.

Helena Konanz: They aren't necessarily leaving the country. Would some of them be leaving the country and going to the United States or to other countries, especially if they have originally been trained in another country and haven't found a pathway to be able to practise?

Rani Srivastava: I think we do lose nurses to the United States. I think many of the internationally educated nurses who come here aren't necessarily leaving the country. This is where their homes are, and this is where their families are, but they are leaving the profession or are leaving full-time employment for casual employment, travel nursing or things that they feel are more manageable, given the practice environment that they're working in.

Helena Konanz: Would you say that some of these nurses who are trained in other countries and who are Canadian or are immigrants from other countries...? Do you think that they're given promises that aren't being kept? You know, they're bringing their families here, and maybe they aren't even able to practise. Would you say that they're being given promises—which is disturbing—so that they come here with certain ideas of being nurses and are not able to practise?

Rani Srivastava: I would say that that's fair, that many people come with expectations that are more positive than the reality that hits them when they come here.

Helena Konanz: Okay.

Did federal immigration consult with the Canadian Association of Schools of Nursing on this year's federal immigration levels, seeing that we have a shortage of nurses and doctors?

Rani Srivastava: I'm not aware of such consultation.

Helena Konanz: Would you like to be consulted?

Rani Srivastava: Absolutely.

The Chair: Thank you very much.

Your time is up, Ms. Konanz.

I'll now go to Ms. Chi from the Liberals for five minutes, please.

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

Thank you to all the witnesses who have appeared before us today. Thank you for your time and your expertise. We really appreciate your perspectives.

My first question does apply to all three, but I want to hear from Dr. Watling first.

I know there was a line of questions that insinuated that immigration is a big pressure point on the system, but we all know that the health care system is under quite a bit of pressure that's very complex beyond that. Would you agree that that's really simplifying the issue that you and your members are facing?

Dr. Christopher Watling: I totally agree that the health care system is under a complex set of strains, yes.

Maggie Chi: Thank you so much.

Could you outline what those constraints are that you are hearing about from your members? There's a global workforce shortage, correct? Could you outline that and the complexity of the health situation that you're experiencing?

The last point is the aging demographic that we're facing as a nation. Can you provide some perspective on that?

Dr. Christopher Watling: I could probably talk for a long time on this. However, briefly, an aging population means increasing

complexity of medical and health concerns and increasing expectations and possibilities in terms of what can be done, which increases the complexity of the work. It's an ongoing administrative burden for physicians that sometimes really makes it difficult for them to keep as much of their focus on patient care as they would like. Also, there are complicated system issues. Then, finally, we have a country where we have a geographic challenge in having health care workers—physicians I can speak to particularly—located where we need them to be.

The shortages and the system challenges are not evenly distributed across the country, as you know, so that's another issue of our geography that I think we need to try to grapple with.

Maggie Chi: Thank you, Dr. Watling.

My next question is to Dr. Srivastava.

Thank you for providing a lot of perspective from your members. I wanted to hear from you in terms of serving remote communities and retention in remote communities. What have your experiences been? What are you hearing from your members? Is there anything we could be doing better and how can we support that?

• (1205)

Rani Srivastava: What we hear from our members is that recruitment and retention in remote communities is a challenge. What helps us is a bit of a holistic approach, where the community and the employers work collaboratively, because people are moving with their families and when it does work, it works very well, in terms of being able to look at providing establishment into the community.

Nursing is still predominantly a female-dominated profession. Therefore, for somebody to go and move to a rural community and find job fulfilment, you also need to have opportunities for schooling for your children...partners, those kinds of things. That's where I see successful models that could be replicated and expanded upon.

Maggie Chi: Thank you so much.

I'll be sharing my time with Dr. Powlowski.

Please go ahead.

Marcus Powlowski: Dr. Srivastava, I think nurse practitioners are a big part of the solution for rural Canada. Where you have maybe two doctors in town, you can share the call with a good nurse practitioner. It doesn't seem to me we're graduating enough nurse practitioners. Do you want to talk a little bit about how many nurse practitioner schools we have and what we can do to try to get our numbers up, and how much that's part of the solution to the problem?

Rani Srivastava: I don't have the exact numbers of NP schools or graduates with me, so I apologize. I don't want to provide incorrect information. I agree with you. NPs are expanding and they are very much a part of the solution, working with physicians in urban centres but also in rural communities as part of team-based care. More work is definitely being done. I think in terms of expanding the scope of practice for the NPs there is a lot of good work that has been done there in both collaborative models working and providing support. I would absolutely support that. We need to continue to expand that and look at models where there is strong collaboration among physicians in remote communities. This is where technology helps to provide the supports needed for new nurse practitioners who may be working without proper mentorship support.

Marcus Powlowski: I will do a quick follow-up with Dr. Watling.

There are a lot of physicians who have been trained overseas who perhaps would be willing to become physician assistants. Especially in remote areas, people with some surgical skills who are practising as physician assistants would seem to me to be a useful avenue. What do you think of the idea of getting more physician assistants out there?

The Chair: I'm sorry. The time is now 15 seconds over time.

Dr. Christopher Watling: I very much agree.

The Chair: I want to thank the witnesses for coming and answering questions.

I'm going to suspend the meeting to prepare for the next meeting. Thank you very much.

• (1205) _____ (Pause) _____

• (1210)

The Chair: I will resume the meeting.

I will now continue with the next group of witnesses. There are three.

I want the committee to know that we will go to 1:05 because we started our meeting five minutes late. My bad on that one.

From the College of Family Physicians of Canada, we have Dr. Carrie Bernard, president.

From the Federation of Medical Regulatory Authorities of Canada, we have Stephanie Price, executive director.

From the Internationally Trained Physicians of Canada, we have Dr. Therese Bichay, director.

I want to let the witnesses know that you have five minutes to present. I will give you a one-minute cue and then a thirty-second cue, because I have to cut you off at the end of that time. We then have a question and answer period. The time allotted is for the question and the answer.

• (1215)

Todd Doherty (Cariboo—Prince George, CPC): I have a point of order. I'm sorry, Madam Chair.

I just feel that I have to make a comment, as I am only briefly sitting in here.

I have served on a number of committees. It is customary that, if a committee is going to sit past the allotted time—we are all busy, and we all have different meetings that we have to go to—the chair will put the question to the committee whether it is okay that we sit past the allotted time. I appreciate that you were late, and you apologized for that, but for you to just arbitrarily say that we're going to sit to 1:05, without first canvassing the committee, is not our normal committee practice. I think it would have been proper to please petition the committee.

We all have to check. I realize it's only five minutes, but we all have to check our schedules, and for you to just arbitrarily say that we're going to sit past one o'clock is an abuse of power, in a sense.

The Chair: Mr. Doherty, I did not actually arbitrarily do it. I told Mr. Mazier. He did not say no. I spoke to the Liberals. They did not say no. I did not ask Mr. Thériault, and that is my only fault. I spoke to everyone else before I began the meeting, though. I'm sorry, Mr. Doherty.

I'll begin the meeting so that we don't waste any more time. I'll begin with the first witness, who is with the College of Family Physicians of Canada.

Dr. Carrie Bernard, please begin.

[*Translation*]

Carrie Bernard (President, College of Family Physicians of Canada): Good afternoon, everyone.

• (1220)

[*English*]

I'm Dr. Carrie Bernard, a family doctor with 25 years of experience practising in Brampton, Ontario, and the president of the College of Family Physicians of Canada.

I'm coming to you today from the treaty and traditional territories of the Mississaugas of the Credit First Nation, the Haudenosaunee Confederacy, and the Huron-Wendat and Wyandot nations.

Thank you for the opportunity to speak to the committee on these important and complex issues, the interaction between immigration policy and the health workforce in Canada.

Family doctors are the foundation of Canada's health care. Our members deliver 50% of all medical services provided to Canadians. International medical graduates comprise 31% of family doctors practising in Canada. We simply do not train enough domestically. International medical graduates and internationally trained physicians play a crucial part in access to primary care and frequently work in rural and remote communities, providing access to Canadians who would otherwise go without.

We know that relative to other OECD countries, Canada trains fewer family doctors per capita. The number is about 4.2 family doctors per 100,000 in Canada, compared with 6 in the U.K., 5.8 in Australia and 6.5 in the Netherlands. A recent Health Canada study estimated that we're almost 23,000 family doctors short at this point in time, and over six million Canadians report not having a regular family doctor. We cannot begin to address these daunting needs without looking to internationally trained family doctors.

As we consider solutions, it's important to clearly state that we must never compromise the high standards of care provided by family doctors. Further, there is no substitute for the type of medical care and expertise provided by family doctors, who are licensed and certified as meeting the standards of the College of Family Physicians of Canada.

While 92% of medical graduates match to their residency spot of choice, only 24% of international graduates do. These are qualified candidates who could, after postgraduate training, be providing care as part of the Canadian system, but there isn't enough capacity to accommodate all of them. We must expand the total number of family medicine resident seats to support Canadian and international medical graduates.

This is consistent with the federal government's pledge to increase medical school and residency spaces, which we applaud, but any time we consider increasing training capacity, it's imperative that proportional investments be made in community practices where the residents learn. These sites cannot accommodate extra learners without support. We want to set everyone up for success.

In addition, introducing arbitrary barriers to qualify for the CaRMS residency match, such as spending two years in an Ontario high school, a requirement that was issued recently, is not a way to bolster our workforce. This could contribute to destabilizing the family medicine workforce pipeline. We should expand capacity, not actively push qualified candidates away.

I think everyone here believes that the immigration process should align with the needs of Canada's health workforce. Current criteria may welcome skilled health professionals through the comprehensive ranking system, but they provide little support for obtaining the credentials needed to contribute to health care once these professionals are living in Canada. We need to expand programs like practice-ready assessment. This could increase the number of physicians who are ready to enter the workforce while actively contributing to care. Like the royal college, we would welcome federal support for this.

The CFPC is also working to streamline certification pathways so that more qualified candidates can join the workforce sooner.

We often see candidates from countries with similar family medicine training who may lack certain components, such as training and education in mental health or obstetrics. While these gaps must be addressed, these professionals can still practise in the areas where they do have competence, contributing to caring for Canadians as they obtain the extra skills they need to be fully certified family physicians. Such programs require funding. Flexible structures will help integrate health professionals faster and expand

workforce capacity. The CFPC is looking forward to supporting this process.

Additionally, instances exist where established physicians are facing issues with their immigration status, such as the highlighted story of Michael Antil, an American physician caring for more than 2,000 patients in Toronto who is struggling to get residency status.

The Chair: Sorry, Doctor, but I think we're running out of time. Please wrap it up. You can fill in the rest in your answer time.

Carrie Bernard: Okay.

We want to maintain standards and support the profession by working towards achieving a family physician for every Canadian and make sure everyone has access. We're happy to have solutions.

The Chair: We'll now go to the next witness, the Federation of Medical Regulatory Authorities of Canada.

Ms. Stephanie Price, you have five minutes. Welcome.

Stephanie Price (Executive Director, Federation of Medical Regulatory Authorities of Canada): Thank you and good afternoon. I'm Stephanie Price. I'm the executive director at the Federation of Medical Regulatory Authorities of Canada. We're the organization that brings together the 13 medical regulatory authorities who regulate physicians, licensing them and making sure they are accountable to the Canadian public.

At FMRAC, our goal is to advance medical regulation and support the medical regulatory authorities, the MRAs, in their work to protect the public. An important priority for FMRAC and the MRAs is ensuring that Canadians have reliable access to safe, high-quality care. Physicians are the engine of the health care system. They provide the skills and professionalism needed to deliver high-quality, safe medical care.

As this committee has noted, we have a shortage of physicians in Canada. Internationally trained physicians, ITPs, can help address that shortage in the short term. Many ITPs are a ready source of the skills, knowledge and care that Canadians need. Currently there are many challenges facing ITPs. The medical regulatory system in Canada is robust, and that's good for Canadians. We expect all our physicians to be competent, ethical professionals, and the MRAs are dedicated to upholding those standards.

While the legislation, policies and practice can vary by province or territory, broadly speaking, applicants for licensure as a physician must meet five requirements. They must be able to communicate with their patients, so there is a language requirement. They are trusted professionals who must act ethically with integrity and honesty, so there is a good character requirement. Because their mental and physical health impacts the care that they provide, there is a fitness to practice requirement. And of course we expect them to have and demonstrate medical knowledge and skills required for care and we expect them to maintain those skills and knowledge through ongoing clinical practice.

For physicians who are educated, trained and maybe even practised outside Canada, there can be challenges in meeting some of those requirements. Pre-immigration, many ITPs are unaware of the requirements of our system, the fact that regulation takes place at the provincial and territorial level, or that there are many different pathways to licensure. One change that could be made to the immigration system would be to provide clear information about licensure, certification and assessment to ITPs. Providing this information well before they arrive in Canada would allow them to make informed decisions about whether or not to choose Canada.

Additionally, for ITPs who are already in Canada, we could provide navigational supports so that they spend their time applying to licensure, not trying to understand the licensure system. Currently, physicians who spend time trying to understand the system lapse in their practice and therefore lose the currency required to gain licensure. Navigational support programs could reduce the amount of time it takes for ITPs to understand and access licensure, getting them into practice and providing care to Canadians sooner. Those navigational supports could also include financial supports to help new immigrants offset the costs associated with licensure and certification.

A second improvement would be to align the language requirements between the immigration system and the regulatory one. Currently, the immigration system has a language requirement that doesn't match that of the regulators, meaning there is extra time and expense for ITPs to meet two different language test requirements.

A third improvement would be to expand how ITPs can demonstrate their medical knowledge and skills. This could include expanding residency programs, which, as we have heard today, train physicians in a specialty and lead to Canadian certification; but we could also expand practice-ready assessment programs. PRA programs are an important way to assess ITPs through direct observation of their clinical skills in a supervised setting. These programs are shorter and less expensive than going through a residency training program.

- (1225)

Expanding the number of PRA programs or the spots in PRA programs would increase the number of ITPs who can be assessed, and if successful, licensed. These programs require funding both for the infrastructure that houses them and for the assessors who work in them, but scaling them up would make a significant difference.

With each of those pathways, it's imperative that internationally trained physicians receive comprehensive onboarding and orienta-

tion so that they understand how the culture and practice of medicine in Canada may differ from in their home country.

FMRAC and the MRAs are committed to upholding high standards and increasing the number of ITPs who can access licensure in Canada. We believe it's possible to do both by improving the links between regulation and immigration and by expanding the number of ways in which licensing requirements can be met, while maintaining high standards and protecting the public and the safety of Canadians.

Thank you.

The Chair: Thank you very much. You're 13 seconds under. Congratulations.

We'll now go to our third witness. From Internationally Trained Physicians of Canada, we have Dr. Bichay.

You have five minutes, please.

Therese Bichay (Director, Internationally Trained Physicians of Canada): Thank you for the opportunity to speak before you today.

My name is Dr. Therese Bichay. I am originally from Egypt, where I completed my medical degree and internship and practised as a family doctor for several years.

Over those years, I had the privilege of walking alongside patients through illness, recovery and sometimes loss. I built long-term relationships with my patients and provided care with compassion, dedication and clinical expertise. Practising medicine was not only my profession; it was and still is my passion and purpose.

Like many skilled professionals, I immigrated to Canada with the hope of continuing my medical career and building a better future for my family. Canada's immigration system in fact awards immigration points for being a doctor, recognizing our skills as valuable to the country's economy and social fabric. However, what many of us discover after arriving is that these points—these promises—do not translate into a pass for licensure. The profession that we were selected and welcomed for becomes instead a closed door, which is very frustrating.

Upon arriving here in Canada, I began the long journey towards licensure. I passed all the required medical exams, had my credentials verified and completed the English language proficiency test repeatedly, as they expire every two years, even though language proficiency naturally improves with immersion in time. I completed observerships, worked as a clinical assistant and am currently working as a physician navigator in the emergency department, yet I'm still not working as a licensed physician.

I continue to volunteer, learn and contribute to my community wherever possible. In addition to all of this, in order to meet the recency of practice requirement, which is a mandatory part of all the licensing pathways, I travel back to Egypt every two or three years to maintain my clinical skills and my recent practice. You can imagine how this has been emotionally, financially and professionally exhausting, yet it is the only option available. In Canada we have no clear or accessible avenues existing for internationally trained physicians to maintain clinical recency if they are not already licensed. It's a big barrier that all the internationally trained physicians face.

Despite all of this, I remain without a licence to practice medicine in Canada and I'm not alone in this. Thousands of internationally educated physicians across the country find themselves in the same position—qualified, experienced and ready to serve, but sidelined and ignored by a system that is fragmented and opaque. This is happening at a time when Canada is in the midst of a severe health care crisis. More than 6.5 million Canadians do not have access to a family doctor. Emergency departments are overwhelmed. Wait times for primary care and specialist appointments continue to grow. Communities, especially rural and underserved ones, are struggling without basic medical care.

Internationally trained doctors face many barriers that prevent them from stepping in and helping, although they are willing. Residency positions are both limited and inequitably distributed, with few spots reserved for international graduates. Practice-ready assessment programs are not standardized across all provinces. Each province has its own eligibility requirements, timelines and quotas, which creates confusion and limits mobility.

Another thing is that nearly all of the pathways require recent clinical experience, yet there are not enough structured, accessible opportunities for international physicians in Canada to obtain it. Many of us are left with no option but to leave the country, if we are even able to do so.

The recognition of credentials favours so-called “approved jurisdictions”, which privileges doctors from a select group of countries while effectively discouraging training from the rest of the world, regardless of quality or performance on Canadian exams.

The last thing is that there are no transitional clinical roles that meaningfully lead to licensure. Many of us are willing to start in supervised or provisional positions that could serve as a bridge, but such pathways are non-existent.

It is profoundly disheartening to feel invisible in a country we chose and now call home. We came here not just to build a life but to contribute meaningfully to our communities and to a health care system that desperately needs support. Instead, we find ourselves

stuck, our experience undervalued, our qualifications questioned and our voices often not heard.

This is a national health care issue. When qualified physicians are blocked from practice and sidelined, patients suffer. When licensing pathways are opaque and inaccessible, we all pay the cost in delayed care, overburdened systems and human lives.

Thank you.

• (1230)

The Chair: Thank you very much.

I'll now go to the question and answer segment, and that begins with a six-minute round. Each questioner has six minutes, and that includes questions and answers.

I'll begin with Mr. Mazier, please, from the Conservative Party.

Dan Mazier: Thank you, Chair.

Thank you to the witnesses for coming here today.

Dr. Bernard, did the federal immigration department consult with the College of Family Physicians of Canada on this year's federal immigration levels plan, yes or no?

Carrie Bernard: No.

Dan Mazier: Did the federal immigration department ask for any data on the current capacity of Canada's health care system?

Carrie Bernard: No.

Dan Mazier: Thank you.

Dr. Bichay, welcome.

You graduated from medical school. Is that correct?

Therese Bichay: Yes, that's correct.

Dan Mazier: You completed your training after medical school. Is that correct?

Therese Bichay: Yes.

Dan Mazier: You worked as a family doctor for multiple years. Is that correct?

• (1235)

Therese Bichay: Yes.

Dan Mazier: You came to Canada with the expectation that you would be able to be a family doctor. Is that correct?

Therese Bichay: Yes, that's correct.

Dan Mazier: Are you currently working as a family doctor in Canada?

Therese Bichay: No.

Dan Mazier: Dr. Bichay, how much money and time have you lost trying to get your medical licence in Canada?

Therese Bichay: I can tell you it's around \$60,000 for now.

Between travelling to get the recency of practice and the cost of tickets, and the cost of exams, the money I pay every year for CaRMS, some practice-ready assessments we need to pay for preparing for exams, and even taking time off my work to study for exams or prepare for anything.... I lose my job sometimes in order to go back to Egypt to get the recent practice. I can tell you it's \$50,000 to \$60,000 for now.

Dan Mazier: Wow, that's heartbreaking.

Dr. Bichay, do you agree that there's a disconnect between the immigration system and the health care system in Canada?

Therese Bichay: Yes, there's a big gap between the two. When you are immigrating, you feel that you are welcomed and the process is easy, that once you come here, it's a clear process—you get your exams done and you will be able to practice. But there's no connection, because when you arrive here, you find a totally different process.

Dan Mazier: You mentioned that you fly back to Egypt every couple of years to practice medicine so you can keep your recency of practice. Why?

Therese Bichay: It's one of the main requirements for all ITPs, internationally trained physicians, that they have to keep their recency of practice in order to be eligible to apply both for CaRMS and for the practice-ready assessment. They need a certain number of hours. They don't need a limited time. You have to have three months or six months, which is a very long time to be outside Canada.

Dan Mazier: Do you believe internationally trained doctors should be assessed before receiving permanent residency, so they know if they're able to practice in Canada?

Therese Bichay: I think they should have a better picture about the process here and have all of the information. They should have the ability to start the process when they are still in their countries before coming here. It would be easier to close the gap of recent practice if we can start all the exams or get all of our credentials and everything done before we come here. It would be much easier.

Dan Mazier: According to the health minister's own department, there are currently over 80,000 health professionals in Canada who are not working in their field. You are one of them.

Therese Bichay: Yes.

Dan Mazier: The government keeps saying that we need more immigrants to solve the health care problem, but they have failed the immigrant doctors who are already here in Canada.

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

Therese Bichay: Yes, for sure, because you have already a big pool of internationally trained physicians here who have already passed all the required exams. They have their credentials verified. They are ready to serve, and they are already contributing to the health care system here by working as clinical assistants, volunteering, doing many things. Why are you bringing more from outside the country when we are still here, and we are already Canadian citizens here?

Dan Mazier: Would you support a national testing standard to more quickly and effectively test internationally trained health professionals that would streamline the licensure process instead of having the fragmented approach in each province?

Therese Bichay: A national process, yes, would be very much easier, but we need it to be a fair and transparent national process, not just a national process. It needs to be fair and transparent, leading at the end to licensure, not just a national process with no guarantee at the end. We need it to be guaranteed that you get your licence at the end.

Dan Mazier: Under the current system, do you think you will ever become a family doctor in Canada?

Therese Bichay: I am hoping. I am trying my best, but with the recent changes, I don't know if this will be possible or not.

Dan Mazier: Do you think Canada needs to increase practice-ready assessment capacity?

● (1240)

Therese Bichay: They need to increase practice-ready assessments. They also need to increase the spots available for ITPs in CaRMS. We need both to be increased. It's a big pool, so it needs a lot of seats to accommodate us.

The Chair: Thank you very much.

I think time is up, Mr. Mazier.

Mr. Powlowski, you have six minutes, please.

Marcus Powlowski: Dr. Bichay, where are you currently working?

Therese Bichay: I'm working as a physician navigator in the Brampton hospital emergency department.

Marcus Powlowski: Would you be willing to come to north-western Ontario? I have several communities in my riding, particularly Rainy River, I would note, which is a small town that had three doctors and currently has no doctors. We'll get to the licensing question shortly. Would you be willing to go up there? The weather is kind of like Egypt but slightly better. In addition, you could buy a house up there for \$200,000. You could get a mansion, unlike in Brampton. Would you be willing to go there if there was an avenue to get you there and allow you to practise medicine there?

Therese Bichay: Yes, for sure. I'm willing to move. We are trying to reach out to all these areas in the north. We are willing to move to the northern areas of Ontario and all over Ontario.

Marcus Powlowski: Absolutely we want you, so let me move to the next part of my questioning.

Ms. Price, who finances your organization? Is there federal money in there?

Stephanie Price: No. FMRAC is funded by the medical regulatory authorities themselves, those 13 organizations.

Marcus Powlowski: So it's through the provinces. I have to say, on the question of whether or not we can license you, that we're kind of limited as the federal government, because licensing is a provincial jurisdiction. We are looking at how we can help this process out.

Which province is doing a good job in terms of practice-ready assessments? I know that it's variable. I know that I was part of, perhaps, having it happen in Ontario. Ontario started practice-ready assessments recently. My understanding is that the number of people going through practice-ready assessments is fairly small, around 60 a year, which hardly makes a dent.

I'll accept the Conservatives' addition to that question: Why? Why aren't there more positions in practice-ready assessments, and which provinces are doing a particularly good job on this?

Stephanie Price: I would say that every province is working hard on this. Some provinces have been doing it for much longer than others. Some are just studying right now how to implement practice-ready assessment programs. I wouldn't be qualified to say which is doing the best job.

Why do we not have more positions? You require assessors in those programs. In some of the programs, assessors are paid and trained, and in some of the programs they are not. Being able to fund those programs would allow us to expand them.

Marcus Powlowski: Is there a province that you think has dealt with this? I've heard that having enough supervisors is an issue. You need to have the immigrant doctor working with a Canadian doctor, and there may be costs associated with that. Is there a model you can give us in terms of which province seems to have been most successful with this?

Stephanie Price: There's a recent example in Nova Scotia. The Physician Assessment Centre of Excellence has done a really good job of setting up a custom-built location for this where they can record the interactions, where they can assess all the individual observable activities with patients and where they have trained the assessors and are paying them. They have created a community of assessors who work together and who I think feel like they are contributing as a community, which makes a difference.

There are definitely some models that would be worth expanding.

Marcus Powlowski: If you could send us the information on that, it could certainly be added to the study. We heard about the importance of top-up training. Which provinces allow that kind of top-up training? It seems like there's a certain number of people who shouldn't have to go through medical school or through a residency but may, as I think you said, need some additional training in certain areas. Which provinces have done a better job with that?

Stephanie Price: I would agree that bridging programs or top-up training would definitely be effective for people who have most of the skills but not all of the skills that we would expect for licensure in Canada. I'm aware of programs that exist in Manitoba to do this, but my lack of awareness does not mean there aren't other programs.

Marcus Powlowski: Would you suggest that the regulatory agencies in Canada, like the nursing schools and medical schools,

ought to be addressing this issue? Is there a vacuum there? We heard from the Conservatives, and I agree, that there are a lot of medical professionals already in this country who aren't being recognized. Would you suggest that the various entities like the medical schools ought to be trying to start programs to address this?

• (1245)

Stephanie Price: Yes, and I think they are. I came from a conference of regulators this week and one last week on the Canadian health workforce, and this is an issue of grave concern for educators and regulators in all of the health care professions.

Marcus Powlowski: Who would be trying to deal with this situation? Would it be the medical schools?

Stephanie Price: It depends on the province, of course. Sometimes those PRA programs are run by the regulators, sometimes they are housed within the medical school and sometimes they are done privately. It varies by province.

Marcus Powlowski: Most of the federal involvement in health care comes through transfers from the federal government to the provinces. My understanding is that we can put conditions on those. There are times when the federal government directly invests in health care. Do you think perhaps a valuable way that the federal government could increase the number of family doctors out there would be to invest directly in programs in provinces that offer practice-ready assessments?

Stephanie Price: Yes, I think funding would help. Practice-ready assessments are an excellent way of getting internationally trained physicians into practice and licensed.

The Chair: Thank you very much.

I now go to Mr. Thériault for six minutes, please.

[*Translation*]

Luc Thériault: Thank you, Madam Chair.

Dr. Bichay, what I'm about to say won't necessarily be any comfort, but I've read a number of articles, and you're hardly the only person in your kind of situation.

That's why I'd like to ask Dr. Bernard what you think of this kind of situation. Do you have any solutions?

[*English*]

Carrie Bernard: First, I want to say we connected just before. I'm from Brampton as well. I'm happy to see that she's getting some experience in the emergency department.

Regarding what was being discussed about bridging programs, the internationally trained physicians are left on their own at this point to try and figure out how they can bridge and how they can obtain whatever they need to obtain to jump through the next hoop. Creating programs to help people get to where they need to be is something we have been working really hard on at The College of Family Physicians of Canada. We're also seeing more collaboration than we've ever seen before with our regulators. We meet with FM-RAC and we meet with the provincial regulators to try and solve this.

It's correct that it's different across provinces, but we need to clearly articulate the paths and clearly articulate and fund ways for people to gain the skills if they are missing them. If there's a hoop they couldn't jump through or there's just one thing they needed to obtain, whether that is a CaRMS spot, if that's what they want, or licensure through the PRA system, we need to allow people to contribute where they're at and bridge them so that when they're done, they can be a fully certified family physician.

There are places where people train internationally. They just don't do mental health, for example. In Denmark, family physicians do not prescribe antidepressants. That's okay to start off when you're here, but you would need to take a course to make sure that, in a couple of years, you could be prescribing antidepressants.

You quite rightly articulated who does it and who pays for it. Our medical schools are struggling; they don't have enough money. We would love to develop a program at The College of Family Physicians, but we're busy dealing with the programs we have right now. We need targeted funding for PRAs and bridging programs and for making sure there are more PRAs. You heard from my colleague who is in Ontario that to even access a PRA would be difficult given the number of spots that we have.

[*Translation*]

Luc Thériault: Dr. Bichay, it's clear that the information Immigration, Refugees and Citizenship Canada provided about the rules did not match your experience when you arrived here. That is also the case in Quebec, where, if I'm not mistaken, there's supposed to be an accelerated recognition process. However, as you explained earlier, one has to have practised uninterrupted for at least three years. People have to apply before they even set foot on Canadian soil. That's a major communication issue.

My comment is for you, Dr. Bichay.

People who come here without having applied ahead of time eventually have to leave the country to practise because they have to keep their practice current. If that takes three years, they have to leave the country a number of times, just as you are doing now.

Citizenship and Immigration's rules and the information it provides aren't clear.

• (1250)

[*English*]

Therese Bichay: Yes. It's not clear.

Like Dr. Bernard was saying, we're not supported here, even by other options to maintain our recent practice, which is a big requirement, obviously, in all of the programs that we are applying to. We

need to have some flexibility and options here, because not all of us can return to our countries to maintain our recent practice. There are financial reasons and family reasons; some have war in their countries. There are a lot of reasons.

We need to have a standardized fast way for filling this gap: for example, a clinical assistance role that can lead at the end to licensure or can help you to get into the PRA program. Some clear pathways and some clear information would help a lot of ITPs to be integrated into the system.

The Chair: Thank you.

Are you finished, Monsieur Thériault?

[*Translation*]

Luc Thériault: I have a question for you, Dr. Bernard.

I don't know how long you've been in your position, but do you remember if Immigration, Refugees and Citizenship Canada even consulted your organization about those targets?

[*English*]

Carrie Bernard: At this point in time, in the time that I've been in the position, there has not been a consultation. This is our first consultation.

The Chair: Thank you very much, Doctor.

I now go to the second round. It's a five-minute round. I think, given the time, that we may not be able to do the whole two parts of the round. We had agreed that we would end at five minutes after.

I'll go to Ms. Konanz for five minutes, please.

Helena Konanz: Thank you, Chair.

My first question is for Ms. Price. It's a yes-or-no question.

Did the federal immigration department consult with the Federation of Medical Regulatory Authorities of Canada on this year's federal immigration levels plan?

Stephanie Price: No.

Helena Konanz: Did the federal immigration department ask your organization for data on the current capacity of Canada's health care system?

Stephanie Price: No.

Helena Konanz: Yes or no, would you like to be consulted?

Stephanie Price: Yes.

Helena Konanz: Thank you.

My next question is for Dr. Bichay.

I want to say first that I am so sorry for what you've had to go through. I appreciate your story, especially since you don't have to go to northern Ontario—you can and that would be great, but—

• (1255)

Todd Doherty: Come to Prince George.

Helena Konanz: —come to Prince George, as my colleague just said. Or come to the Okanagan, the Boundary Country, the Kootenays or Similkameen in my region in British Columbia, and you will find hospitals that are closing for multiple days a year. Emergency rooms are closing suddenly, some for 50 days a year, because they don't have enough doctors and nurses. I really appreciate your story, and I'm glad we're going to do something about it.

Dr. Bichay, it has been reported that there are 5,000 internationally trained physicians practising in B.C. Do you have an estimate for how many physicians, nurses and other medical professionals might be trained but are unable to practise in British Columbia?

Therese Bichay: I don't have an exact number, but I know there are thousands of us all over the country, in every province.

Helena Konanz: Dr. Bichay, with your heartfelt story, were you promised a position as a doctor? Were you promised that before you came over, before you committed your life and your family's lives to moving to Canada?

Therese Bichay: When you see that your immigration scores top up because you are a doctor, you feel that you're going to be appreciated. You feel that you're going to have an opportunity to practise medicine over here. When you feel that your credentials are verified, you feel that this country is welcoming you and that they need you, but when you land here, you find many barriers coming one after the other. When you fulfill one requirement, you get other barriers.

Helena Konanz: It sounds like that.

Is there an issue where internationally trained professionals in Canada can't get credentials recognized in Canada and then go to the United States instead?

Therese Bichay: I've seen many people.... After trying for many years, of course, you lose hope. You cannot keep pushing here if you cannot practise your profession in the end. If you're offered...in another country, either the U.S. or U.K..... I've seen people going to Australia. If you see that there's an opportunity for you, you go there, of course.

Helena Konanz: I'd like to cede my time to Dr. Strauss.

Matt Strauss: Thank you.

Dr. Bernard, thank you. That was a really helpful presentation, and some of the numbers were very stark. You said that we're 23,000 family doctors short in Canada and that 6.5 million Canadians don't have access to a family doctor.

Not to put too fine of a point on it, but would you agree with me that if I'm one of those 6.5 million Canadians who don't have access to a family doctor, I'm definitionally not receiving proper health care?

Carrie Bernard: Thank you.

Having a family physician is a super important part of having access to the excellent health care that Canadians all expect and deserve.

Matt Strauss: Definitionally, 15% of Canadians are not receiving proper health care right now, based on those stark numbers.

When you hear Dr. Bichay's story, in your view, does your organization have a pretty good idea of when somebody...?

When Dr. Bichay gives her demographic data, such as her age, the med school she went to and her test scores—the sorts of things she gave to Immigration Canada—would your organization have a pretty good sense, based on data, of whether she's likely to be successful in obtaining a Canadian licence?

Carrie Bernard: I don't think we have drilled the data down to the likelihood of success because there are so many factors. It's very dependent on province, what is needed in each province and what particular.... The PRAs in certain provinces will allow somebody to practise without certain skills but not other provinces.

It would be difficult to guess whether someone—

Matt Strauss: Thank you.

Ms. Price, when you hear that, I should think that if the family doctor college gives an immigrant with permanent residence the proper certification, they would almost certainly be able to practise in each province.

Stephanie Price: Yes, certification is one of the important requirements in every province and territory, but, as you've heard from Dr. Bichay, currency of practice will also be an issue for many ITPs.

Matt Strauss: Could you give us a sense, of those who do obtain FCFP, what proportion of those will be allowed to practise in one or another province?

Stephanie Price: I would think all, but I'm not certain.

Matt Strauss: Thank you.

The Chair: I'm going to go now to Mr. Eyolfson for five minutes for the Liberals.

Doug Eyolfson: Thank you, Chair.

Thank you all for coming. It's very valuable testimony.

Dr. Bernard, it's good to see you again. I enjoyed that evening reception—I and Dr. Mazier were there. There's an inside joke about something that happened there before I fell down....

One of the common themes that we've found—again, in my previous tenure in the federal government—is that, when we want to give funding to provinces for a given initiative, there's sometimes some push-back. They say, “You give us the funding,” but they are resistant to targeted funding.

If the federal government were to come up with funding directly for things like supporting these practices, to do practice-ready assessments, would you advocate to the provinces and say, "Allow the federal government to do this without invoking the Canada Health Act to say, 'You're not allowed to do that'"?

• (1300)

Carrie Bernard: At this point in time, I think 100% there's a huge appetite for working together across provinces to better supply people with family physicians. If it's ever going to happen, it can happen now. I think everybody can get behind whatever it takes to help people who have the skill to care for Canadians to get to the right place to care for them.

Doug Eyolfson: Thank you.

My next question is for Ms. Price, and thank you for coming.

You talked about the criteria that the regulatory agencies have for practice and listed them all. When someone does a residency, whether it's a College of Family Physicians of Canada residency or a royal college residency in surgery or obstetrics or psychiatry, they also have those in their criteria. I cannot graduate from a royal college residency without also satisfying all of those criteria. I would not be considered eligible to write my exams. Before writing them, I would not have my FRCP.

What is your view on saying that if you have satisfied these criteria in one of these residency programs, it should be enough to practice medicine in any given province?

Stephanie Price: That does it. People completing residency programs in Canada and sitting their exams and becoming certified will meet the requirements for licensure.

Doug Eyolfson: Okay, but what I'm saying is that without the process...

For instance, I did a residency in 1998 and applied for my licence through the provincial process. I had a licence in Manitoba. I had an opportunity to also do some work in Ontario. I had to submit a tremendous amount of paperwork, including a letter from my medical school. I was one of the last people who did the old-fashioned internship. I had to get a letter from my medical school where I did the internship. I had to get a letter from the royal college. Not only did all of this take time, but I had to pay for all of these things as well. This was all at my expense, with a tremendous amount of work and delay.

Why would the fact that this was good enough for Manitoba not mean that it was good enough for Ontario? Why couldn't the Ontario college say, "Did he submit all of this stuff? That's great. Here we go."?

Stephanie Price: The National Registry of Physicians will help us do that, because, as the Canadian Free Trade Agreement allows, if you are licensed in one province or territory, you can become licensed in another with minimal assessment.

When moving from one province to another, your language and your character can be checked. Those are the two things on which physicians may be asked to submit supporting documentation when they are trying to achieve licensure today, but I would say that a lot of progress has been made and that mobility is much better.

I'm not sure when your personal experience took place, but—

Doug Eyolfson: This was in the early 2000s.

Stephanie Price: —there have been significant improvements, and more are coming, thanks to the National Registry of Physicians and our collaboration with the Medical Council of Canada.

Doug Eyolfson: In my last 15 seconds, is there a barrier to the colleges' accepting one licence that could be transferred to another province, or at least recognized in another province?

Stephanie Price: There isn't a barrier to the recognition. There are checks and balances to ensure that concerns over a physician's conduct in one jurisdiction are known in a second jurisdiction where they're licensed, but I wouldn't call those barriers.

The Chair: Thank you very much.

I now go to Mr. Thériault for two and a half minutes, please.

[*Translation*]

Luc Thériault: Thank you, Madam Chair.

Dr. Bernard, the population is aging more rapidly in Quebec and Ontario than in other parts of the country, yet more family doctors are not being trained. We have a training problem. We're not training enough family doctors.

Moreover, even though we want to train more of them, the problem we're running into in Quebec is that people tend to want to specialize instead of becoming family doctors.

Why do you think that is? We need resources to train more family doctors, but since we don't have those resources, we obviously have to integrate foreign-trained doctors.

In your opinion, why don't we have the resources to train doctors?

• (1305)

Carrie Bernard: Thank you for the question.

[*English*]

Most people who do locums the way you're describing in smaller communities are actually family physicians. They have general practice family physician training and they're more portable.

Newly trained internationally trained physicians, once they obtain licensure, are also free to work like this. I would put it that it might be a bit more difficult for them initially in adapting to other communities. They probably would prefer to serve—

[*Translation*]

Luc Thériault: Okay, but why aren't we training enough doctors?

[*English*]

Carrie Bernard: It's a very good question. The decision is left to the provinces in terms of how many spots go to each speciality or subspecialty. That decision is made every year.

There has been, in certain provinces, an increase in training spots. We have new medical schools that are devoting more time to family medicine specifically. This is a move in the right direction, which we applaud.

At the college, we have many suggestions that we have been sharing with your colleagues on how to increase the number of family physicians across the country, but it is an ongoing issue for which we need solutions.

[*Translation*]

Luc Thériault: Isn't there also a lack of resources to train more doctors and create more positions?

[*English*]

Carrie Bernard: Yes. We need funding for physicians. We also need funding for learners. They have to go somewhere. The people

who are overburdened in their clinics need space for learners to train. It requires a whole approach to providing greater support.

The Chair: Thank you.

I want to thank the witnesses for taking the time to come and present to us. I am going to now move that we adjourn.

Dan Mazier: I have a point of order.

Have we had any word back from the immigration minister about a date when she will appear in committee?

The Chair: I will ask the clerk.

No, we have not. We have heard from Health, but not from Immigration.

This meeting is adjourned.

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