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Tuesday 4 December 2001

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Mardi 4 décembre 2001

Standing committee on justice and social policy

Health Protection and Promotion Amendment Act, 2001

Comité permanent de la justice et des affaires sociales

Loi de 2001 modifiant la Loi sur la protection et la promotion de la santé

Chair: Toby Barrett
Clerk: Tom Prins

Président : Toby Barrett
Greffier : Tom Prins

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON JUSTICE AND SOCIAL POLICY

COMITÉ PERMANENT DE LA JUSTICE ET DES AFFAIRES SOCIALES

Tuesday 4 December 2001

Mardi 4 décembre 2001

The committee met at 1610 in committee room 151.

HEALTH PROTECTION AND PROMOTION AMENDMENT ACT, 2001

LOI DE 2001 MODIFIANT LA LOI SUR LA PROTECTION ET LA PROMOTION DE LA SANTÉ

Consideration of Bill 105, An Act to amend the Health Protection and Promotion Act to require the taking of blood samples to protect victims of crime, emergency service workers, good Samaritans and other persons / Projet de loi 105, Loi modifiant la Loi sur la protection et la promotion de la santé pour exiger le prélèvement d'échantillons de sang afin de protéger les victimes d'actes criminels, les travailleurs des services d'urgence, les bons samaritains et d'autres personnes.

The Chair (Mr Toby Barrett): Good afternoon, everyone. We're considering Bill 105, An Act to amend the Health Protection and Promotion Act to require the taking of blood samples to protect victims of crime, emergency service workers, good Samaritans and other persons.

We have a motion from the House:

"Resolved that this Legislative Assembly of Ontario direct that Bill 105, An Act to amend the Health Protection and Promotion Act to require the taking of blood samples to protect victims of crime, emergency service workers, good Samaritans and other persons, be considered by the standing committee on justice and social policy, Tuesday, December 4, for one day, at the end of which the Chair shall put every question necessary to dispose of clause-by-clause consideration of the bill; and

"That it then be reported back to this House and ordered for third reading.

"That when third reading of Bill 105 is next called, the question be put immediately without debate or amendment."

So we have clause-by-clause consideration on our agenda.

CHIEF MEDICAL OFFICER OF HEALTH

The Chair: However, before that, we have a presentation from the chief medical officer of health, Dr Colin D'Cunha. Doctor, will you come forward, please?

Dr Colin D'Cunha: Good afternoon, members of the committee and honourable Chair. I apologize for not having a copy of my presentation pre-circulated, but I was only advised of the presentation on Thursday afternoon, and we've been working away on it until earlier today. With me is Christine Henderson, legal counsel from the Ministry of Health and Long-Term Care, who is assigned to public health matters with the ministry.

I'm honoured by your invitation to make submissions today on Bill 105, and as chief medical officer of health for this province, my submissions necessarily concern the impacts that Bill 105 may have upon public health in the province from a practical, a policy and a legal perspective.

It is very important that I say to you that I understand the difficult circumstances that emergency service workers, good Samaritans and others sometimes face. We are all grateful for their devotion and commitment in protecting the public safety.

Mr Chair, I wanted to be very clear at the outset that I fully support what I believe to be the intention of Bill 105, which in my view is to protect or enhance the health of emergency service workers and others. However, respectfully, I must also be clear in my submission that Bill 105 has not been drafted in a way to realize its laudable intention.

In my presentation today I will first discuss the existing framework that is designed to protect the health of emergency service workers and others in Ontario. I will also be discussing the OMA-OHA blood-borne diseases protocol for Ontario hospitals, as well as the current guidelines and protocol for the notification of emergency service workers, which also applies to good Samaritans.

Next, I will compare Bill 105 and the Health Protection and Promotion Act. In this part I hope to go into some detail about the differential purposes between Bill 105 and the Health Protection and Promotion Act. It should be noted that under Bill 105 the role of the medical officer of health shifts significantly. I will discuss that shift and whether, in my view, that shift is or is not a good thing. I will also discuss the difference between orders under Bill 105 and the existing public health legislative scheme and some of the problems with the test under Bill 105.

From a public health perspective, it is important that we all be clear where our focus should be in a possible

incident of disease exposure on the contact or on the at-risk person. I will discuss this as well.

Finally, I will discuss some of the significant issues the bill raises respecting confidentiality and privacy matters.

Turning my thoughts then to existing protocols, health care workers and emergency service workers, my initial comments are going to focus on the Ontario Hospital Association/Ontario Medical Association/Ministry of Health and Long-Term Care blood-borne diseases surveillance protocol for Ontario hospitals. This protocol was developed jointly by the expert committee of the Ontario Hospital Association and the Ontario Medical Association. On a personal note, I will point out that prior to my taking my current position I was a member of this committee. This protocol was first developed in 1990 and revised in May 2000 to keep it current on developments in the science field.

The blood-borne diseases surveillance protocol is approved by the Minister of Health and Long-Term Care under the regulation under the Public Hospitals Act. The purpose of that protocol is to provide direction to hospitals for preventing transmission of blood-borne pathogens from persons carrying on activities in the hospital, including health care workers to patients, or from patients to health care workers. The objective is to clearly establish a system for managing potential exposures to blood-borne pathogens, especially the hepatitis B virus, the hepatitis C virus and the human immunodeficiency virus, among persons carrying on activities in the hospital.

Exposed persons and their personal physicians are responsible for follow-up care and therapy if disease transmission occurs. In the protocols, the term "exposed person" refers to any person carrying on activities in a hospital who has been exposed to the blood and body fluids of patients through injury from a contaminated needle or sharp object, a splash onto a mucous membrane or non-intact skin, or a human bite that breaks the skin.

The importance of the reporting of exposure incidents is highlighted under the protocol. Procedures to be followed post-exposure are outlined for either unknown-source or known-source situations. Note, under the category of known source in the protocol is the following statement:

"Whenever there is a possibility that a health care worker has been exposed to a blood-borne virus, the issues of patient confidentiality and employee rights may conflict. This is an ethical dilemma for which there is no simple solution. The procedures were developed according to the principles of both practicality and respect for these apparently opposing rights."

If the source patient agrees to testing, "ascertain whether the exposed health care worker is willing to be tested for antibody to hepatitis B virus, hepatitis C virus and human immunodeficiency virus. If the exposed health care worker is not willing to be tested, do not test the patient (when the exposed person is not tested, there is no value in testing the patient source)."

Under the protocol, without the baseline testing of the health care worker, any subsequent claim for compensation from the Workplace Safety and Insurance Board may be denied.

The current protocol has worked well in health care settings, an environment which is at higher risk for the acquisition of blood-borne pathogens. While there have been documented cases of disease transmission in health care settings, health care worker to patient in Ontario and Canada, it is important to note that at this time there have been no documented reports of emergency service workers acquiring blood-borne pathogens occupationally in Ontario or Canada.

Moving along to the second protocol that I referred to in my introduction, the mandatory guideline and protocol for the notification of emergency services workers, I now turn to consider an overview of the existing guideline and protocol for emergency service workers in Ontario. In my respectful view, the protocol serves as a viable alternative to Bill 105.

First, some background. In 1994, to address the safety concerns of firemen, police officers and ambulance attendants, the public health branch of the Ministry of Health and Long-Term Care introduced a mandatory guideline and protocol for the notification of emergency services workers. This guideline and protocol was developed and approved by a multifaceted joint committee representing fire chiefs, firefighters, police, OPSEU representing ambulance personnel, the offices of the fire marshal, Solicitor General and emergency services, senior public health officials and a member of the Ontario Hospital Association.

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The purpose of this protocol ie, the protocol for notification of emergency services workers, is to ensure that emergency services workers are notified of specific disease exposures so that appropriate action may be taken. The protocol specifically names the following blood-borne diseases: HIV/AIDS, hepatitis B, and diseases spread by the respiratory route, such as meningococcal disease and infectious tuberculosis.

Under the protocol, each emergency service organization must appoint a designated officer. Wherever possible this should be done in consultation with the joint occupational health and safety committee. Emergency service workers who believe they may have been exposed to one of the specified diseases are to report the exposure to their designated officer. The designated officer makes a determination of whether an exposure seemed possible during that incident.

A manual entitled Preventing and Assessing Occupational Exposures to Selected Communicable Diseases was developed to assist designated officers in such situations. If the designated officer believes an exposure may have occurred, he or she contacts the local medical officer of health, supplying all the details of the incident. The medical officer of health, as soon as practicable but not later than two working days, will inform the designated officer of any specific action to be taken.

This protocol also applies to good Samaritans and off-duty emergency service workers.

The protocols and the manual for the designated officers were distributed to all 37 health units in the province by the ministry's public health branch. In addition, the emergency health services branch of the Ministry of Health distributed the documents to the 195 ambulance services, the 876 fire departments, the 116 municipal police forces and to all districts of the Ontario Provincial Police force. A video has also been developed and distributed by the emergency health services branch to help educate designated officers.

If it is felt by the emergency service organization that the above protocol is not working as intended, it may be appropriate to investigate any complaints and respond appropriately. The emergency health services branch has provided the secretariat for fielding such complaints in the past.

I would like to stress that it is important to note that we have no reports of occupationally related disease transmission in Ontario or Canada of emergency services workers.

I turn my attention to Bill 105 and the Health Protection and Promotion Act. In this discussion I would like to compare and contrast certain provisions of Ontario's existing public health legislation, the Health Protection and Promotion Act, to Bill 105. I need to stress again that I fully support what I believe to be the spirit of Bill 105 and its objective. The question we all need to ask as we carefully review the bill as to whether this particular amendment will in fact achieve its aim is, will Bill 105 protect or enhance the health of emergency services workers and others it is designed to protect?

The purpose of Bill 105 and the Health Protection and Promotion Act: turning first to consideration of the purpose of Bill 105 and the Health Protection and Promotion Act, the Health Protection and Promotion Act currently provides for a comprehensive legislative scheme for public health concerns across the province. The Health Protection and Promotion Act provides medical officers of health with significant powers to protect public health.

The purpose of this act includes the prevention of the spread of disease and the promotion and protection of the health of Ontarians. Let me repeat that: the purpose of the Health Protection and Promotion Act is to prevent the spread of disease and to promote and protect the health of the people of Ontario. In contrast, Bill 105 makes clear that its purpose is to protect the interests of a single applicant in what may be viewed as an occupational setting. This is where the divergence of principles underlying Bill 105 and the current public health legislative scheme begins. This significant change underlies much of what is wrong with Bill 105 from a public health perspective.

The role of the medical officer of health under Bill 105 and the Health Protection and Promotion Act: a reasonable question to consider at this juncture is how this shift in purpose, from protection of the public health generally to protection of the interests of a specific applicant, will affect the role of medical officers of health. Under the Health Protection and Promotion Act, the medical officer of health is a key statutory official whose role includes overseeing the delivery of public health programs and services in the health unit, the prevention of the spread of disease and the protection and promotion of public health. Under Bill 105, the medical officer of health will act as a jurist, as a kind of demi-judge, if you will, deciding whether or not to order the compulsory taking of a blood sample in a kind of dispute between two parties. It is possible that the bill's requirements will result in an adversarial environment between the parties. It is true to say that when orders are made by a medical officer of health or a court pursuant to the Health Protection and Promotion Act, the civil liberties of the subject of the order are clearly at issue. When the legal test under the existing Health Protection and Promotion Act is met, a blood sample may be ordered taken by a local medical officer of health.

It is my submission that the purpose of the Health Protection and Promotion Act, which includes the protection of the public health and the procedural protections under that existing scheme, justifies the intrusion on the rights and the civil liberties of the subject of the order. I am uncertain as to whether the purpose of Bill 105 justifies the intrusion on the rights of the subject of an order under the bill. I say this bearing in mind the risk assessment and statistics respecting reports of disease transmission involving these applicants and other less intrusive but more effective means available to achieve the goal of protecting the applicant's health.

Practically speaking, given the numbers of medical officers of health and associate medical officers of health across the province, it is surprising that few communicable disease orders are made by medical officers of health each year under the Health Protection and Promotion Act. One of the reasons may be that as a matter of sound public health practice, first response measures to a communicable disease problem generally include voluntary public health measures such as counselling, education, follow-up, offers of testing and referrals for appropriate treatment or community-based support. These are some of the tools medical officers of health may rely upon before making an order under the Health Protection and Promotion Act to protect the public health.

In sharp contrast, Bill 105 suggests that the appropriate first response to a possible incident of disease exposure is an application for an order to a medical officer of health, who will sit as a kind of judge between two parties, with the interests of the applicant being paramount. In my view, this may not be an appropriate role for a medical officer of health and will limit their ability to deal in more effective ways with a public health concern relating to a possible incident of disease exposure.

Mr Chair, you and the committee heard earlier about existing protocols, developed by experts in the field and indicated for possible disease exposure. Bill 105's

approach is generally not an appropriate or effective first response tool from a public health perspective, nor is the shift in the role of the medical officer of health.

Orders under Bill 105 and the Health Protection and Promotion Act: as you may know, the Health Protection and Promotion Act deals with risk to the public health. At present, section 22 of the act gives the power to a medical officer of health, where the legal test is met, to make an order requiring a person to submit to an examination by a physician to determine whether the person is infected with a communicable disease. Where appropriate, this examination may involve the requirement to provide a blood sample. In such cases, the Health Protection and Promotion Act says that the provisions of Ontario's Health Care Consent Act, 1996, do not apply. I note that there is no reference to Ontario's health care consent legislation in Bill 105 relating to the compulsory taking of a blood sample, which may be problematic.

How does the bill attempt to deal with the protection of the interests of a single applicant? In brief, the bill provides a statutory right to certain applicants—a victim of crime, persons providing emergency first aid and others set out under regulation—to apply to a medical officer of health for an order. The order compels the subject of the order to provide a blood sample and its analysis results will be provided to the applicant. I am oversimplifying the test and some aspects of the bill, but that is it in a nutshell.

It is important to note that the Health Protection and Promotion Act provides for a comprehensive procedural code and grants substantive and procedural rights to a person who is the subject of an order. These protections are important, because, as I have said before, a person's civil liberties are at issue.

These important protections will also apply to persons who are subjects of orders under Bill 105. However, they may tend to delay even further the only information that Bill 105 is trying so hard to provide to the applicant, ie, the results of the subject's blood test.

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Under the provisions of section 44 of the Health Protection and Promotion Act, an order by a medical officer of health must inform the subject that they are entitled to a hearing by the Health Services Appeal and Review Board within 15 days after a copy of the order is served on the person. The subject of an order may also apply for a stay of the order until the proceedings before the board are heard and dealt with. This means that a subject who has been ordered to provide a blood sample may ask the board for a hearing and may also ask for a stay of the order, which may significantly delay the process Bill 105 contemplates.

Given these procedural issues, I respectfully request the committee to again consider the question I posed earlier: will Bill 105 in fact protect or enhance the health of emergency services workers and others? Or does a more effective, timely and less intrusive means to this end already exist? In my respectful view, such a scheme already exists.

A few comments on the test under Bill 105 and clause 22.1(1)(d): under the test under Bill 105, one of the issues a medical officer of health must consider is their opinion, on reasonable grounds, that taking a blood sample from a person will not endanger their life or health. This is set out in clause 22.1(l)(d) of the bill. From a public health perspective, this is problematic. Under the bill, the medical officer of health is not provided with access to any health information about the subject of the order, nor is access provided to the subject's physician.

The key question to be posed here is, how then will the medical officer of health make a determination about the health of the subject and any health risk in taking a blood sample without access to their personal health information? In addition, there is no access under the bill to the health information of the applicant. As a practical matter, knowledge of the health issues of the person who may have been exposed to infectious diseases is critical in assessing their risk. From a public health perspective, this particular situation poses a problem.

If an order is made under Bill 105 and if the subject submits to having a blood sample taken, "reasonable attempts" must be made to deliver the blood analysis results to the subject and the applicant. Section 22(5) of the bill requires the medical officer of health to provide the applicant's address to the lab analyst. However, the bill is silent as to how critical personal information about the subject—his or her name, address and so on—is to be accessed. Without this information volunteered by the subject or provided by the applicant for the order, the medical officer of health will be unable to do what they are asked to do, ie, order that results be available to the applicant. This also may pose a problem.

In addition, the bill makes no provision for the baseline testing of the applicant, as outlined under the Ontario Medical Association/Ontario Hospital Association protocol that has been part of our health care workers' guidelines in hospitals for over a decade now. The OMA-OHA protocol, dealing with workers where there is demonstrable risk of disease transmission, where there is evidence of reported cases, includes baseline testing of the health care worker as part of the protocol. One considers this to be very important, yet I note there is no requirement or recommendation for baseline testing of an applicant within Bill 105.

To sum up on this point, without baseline testing of both parties, inappropriate medical action may be taken that may be detrimental to the applicant if a full medical history of both parties is not provided. As we have noted, no access to the medical histories of the parties is available under the bill.

Comments now focusing on the subject of the order or the person at risk: the thrust of Bill 105 is to focus upon the subject of an order—making an order compelling the taking of a blood sample respecting a subject, analysis of the subject's blood sample, provision of the information about the results of the analysis to the applicant and the subject of the order.

You heard me refer to existing protocols. We know there is not a simple solution to these difficult cases. But under these protocols, in an emergency situation where a possibility exists of infectious disease exposures, from a public health perspective the focus should appropriately be on the person who may be at risk.

Protecting our emergency service workers in situations where there may have been an occupational exposure means focusing fully on assessing the situation of the person who may be at risk and offering counselling, baseline testing and prophylaxis where appropriate. From a public health perspective, I am not convinced that Bill 105, with its focus on the subject instead of the at-risk person, assists the emergency services worker in the objective of reducing or preventing the spread of disease.

Some comments on Bill 105, the HPPA and confidentiality: I am concerned about issues involving confidentiality under Bill 105. Currently, under the Health Protection and Promotion Act, no person may disclose to any other person any information that is likely to identify someone who has been reported as having a reportable or communicable disease. These strict legal rules work hand in hand with good public health practice rules.

Sound public health practices require strict confidentiality respecting personal identifying information of an index case, ie, the initial disease case, who has been reported as having a communicable disease. For example, public health officials will never confirm or deny the identity of a partner to a person who may have been exposed to a disease by the partner, as, for example, sexually transmitted diseases. Bill 105, in pitting the applicant against the potential subject of an order, turns these long-standing confidentiality rules on their head.

Another serious privacy issue concerns the applicant's access to the subject's personal health information that the applicant is entitled to receive. If Bill 105 is proclaimed, the applicant should be required to maintain strict confidentiality respecting this information and to undertake not to disclose or use it for any purpose other than the purpose related to the order. The committee may wish to consider offence provisions for violations of this requirement.

Finally, the provisions shielding the subject's health information from use in proceedings under section 22.1(10) of the bill are too narrow. The provision shields the health information only from criminal proceedings. Disclosure in any proceeding might raise serious problems for the subject of the order. Once disclosed, the subject's personal information may be beyond their control. If Bill 105 is proclaimed in law, the disclosure should be prohibited in any proceeding except for a purpose related to the public health proceedings.

In conclusion, let me say that we in public health understand the very difficult circumstances that emergency services workers, good Samaritans and others sometimes face. We are all grateful for their commitment and dedication to public safety. However, it is important to note that within the existing public health legislative framework, medical officers of health already have the power to make an order, where the legal test is met, to require a person to submit to examination to determine whether they are infected with a specified disease, in the interests of protecting public health. As we have heard, the purpose of Bill 105, in contrast, is to protect the interests of a single applicant. This pits an applicant against the possible subject of an order and places the medical officer of health in the uncomfortable new role of judge. This fundamentally shifts the role of the medical officer of health.

Under the bill, a person will be forced to provide a blood sample for analysis. This may be seen as a significant violation of personal privacy and bodily integrity and focuses attention on the disease status of a contact, resulting in information of possibly little or no value, rather than focusing on fully assessing the situation of the person who may be at risk.

Finally, and very importantly, the legal and ethical rules of sound public health practice respecting confidentiality and privacy issues involving patients are ignored under this bill. The better option is to reconsider the existing protocols for emergency services workers and to deal with incidents of possible disease exposure within the existing public health framework.

Mr Chair and members of the committee, I thank you for the opportunity to address you on these important issues.

The Chair: I wonder if any of the parties have comments or questions. I'll begin with the Liberal Party.

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Mrs Lyn McLeod (Thunder Bay-Atikokan): I do have some questions. I appreciate the time you've spent in responding to this, Dr D'Cunha, although I guess I'm hoping—and Mr Dunlop can respond to this, perhaps, when the time comes around—that the Minister of Health or the ministry would have had some discussions with Mr Dunlop, as the presenter of the bill, at an earlier stage than this. I suspect that this presentation put you in a somewhat awkward position today to respond, unless you had some prior indication that there were these concerns.

I want to specifically ask—you mentioned the legal test that has to be met in order for a medical officer of health to make an order requiring a person to submit to an examination. Can you, fairly briefly, tell me what that legal test would be?

Dr D'Cunha: It is essentially where a medical officer of health has reasonable and probable grounds to believe that a person may be infected with an agent of communicable disease. The medical officer of health applies his or her mind to the circumstances surrounding the case of the person who may be infected. If the test is met and determines that there is a risk to public health, then consideration may be given to the public health, including starting off with counselling, amidst other things. Very rarely does one reach the stage of actually writing a section 22, because the initial workup generally seems to address most of it.

With the permission of the honourable member and committee, I'd like to quote the relevant part of the

statute for your benefit, if I may. This is section 22(2) under the act as it currently stands:

"A medical officer of health may make an order under this section where he or she is of the opinion, upon reasonable and probable grounds,

"(a) that a communicable disease exists or may exist or that there is an immediate risk of an outbreak of a communicable disease in the health unit served by the medical officer of health;

"(b) that the communicable disease presents a risk to the health of persons in the health unit served by the medical officer of health; and

"(c) that the requirements specified in the order are necessary in order to decrease or eliminate the risk to health presented by the communicable disease."

The key word here is "necessary." If some other means have been put in place that achieve the desired end of protecting the public health, then the legal test may not be met and there's no need to issue a section 22.

Mrs McLeod: I appreciate that. I think there are some specific concerns that need to be addressed through the regulatory process, and maybe we can have some discussion of that as we go through clause-by-clause.

My understanding of what you've presented us with today—and let me set aside the confidentiality issues for a moment, because I do think confidentiality issues need to be addressed, whether in the bill through amendment or by regulation. But I think the balance of what you have presented, as I understand it, is that what exists now applies to a broad group of people and therefore is manageable and constitutional, but because Bill 105 applies to specific groups of people or an individual applicant, somehow we're concerned about it. Given the added degree of risk and concern that emergency workers have professionally, I'm having trouble with the distinction. It seems to me that if what currently exists is not being really violated in principle by Bill 105, that the protocols are being incorporated in a way that's still consistent with the HPPA—I didn't know about the protocols. I don't know how many emergency workers on the front lines know the protocol exists. What Bill 105 does is it essentially takes that, puts it into law and says, "Here it is. Be comforted."

I'm a little discomforted by the sheer amount of time that any of this is going to take. There are certainly groups that have expressed real concerns about the bill, one of them being the Canadian HIV/AIDS Legal Network, and let me recognize the legitimacy of their concerns. But in one of the background papers they presented us with, it stresses the fact that treatment has to begin ideally within one to two hours. What you're telling me is that Bill 105 doesn't address that, but neither does the existing protocol or the HPPA. The emphasis on education and broader public health prevention measures I think is all fine, but the issue we're trying to deal with in 105 is the immediacy of a situation where treatment would have to begin ideally within one to two hours. I recognize how difficult it is to manage, but it seems to me that what the bill's trying to do is at least give people a chance.

Dr D'Cunha: Essentially, as I stated earlier, the bill focuses on the occupational health of that individual emergency services worker or good Samaritan or member of the public at large who's in that situation to go and seek a blood test, which is the wrong way of addressing their concern. What the protocol in force right now requires is an assessment of the exposure and an element of clinical judgment brought to bear on that set of circumstances. If the exposure is significant and meaningful and if the situation is a high-risk situation for such an exposure, then the clinical decision is to start prophylaxis whilst awaiting test results. You address issues of confidentiality by taking appropriate consent, because there are significant issues in someone's HIV status, for example, being made known to all and sundry. One has to be extremely cautious given that we know how people suffering with HIV are discriminated against. That's one perspective.

It appears to me that what I'm really hearing and what I'm taking in right now is that there is a perception that from an occupational health standpoint, the concerns of our emergency services workers are not being addressed in a manner that satisfies them. It seems to me that Bill 105 is not the way to go there. The way to go there is to address that side of the equation.

Mr Michael Bryant (St Paul's): Two issues. First, with respect to the legal arguments you're putting forward—and you'll forgive men as a rookie MPP, if my civics aren't as good as they should be. You're an officer of the Legislature; you report to the Legislature, not the ministry?

Dr D'Cunha: I don't. I report to the Deputy Minister of Health as chief medical officer of health.

Mr Bryant: Good. In which case, your legal opinions, while obviously very important, really are speaking to matters that I think the Ministry of the Attorney General should be providing an opinion upon. While obviously your legal opinions, as I say, are very valid and relevant, it's really the government which has to take a position as to the legality of this.

This is my concern, that a number of your arguments bootstrap the legal arguments. The concerns about civil liberties, about privacy and so on are important issues that have to be addressed, but I think they can be separated out from the medical issues, and I'd like to hear from the Ministry of the Attorney General or the parliamentary assistant the position of the government on that. Once you remove those legal concerns, then it comes down to one where you're saying—I'm probably totally dumbing down your argument and I regret that, but time is short—that you're uncomfortable playing this new role of what you put as "judge." Well, you have to exercise discretion under the current powers. This is an exercise in discretion. They're not asking you to play an adjudicative role. The Legislature is saying, "We would like the medical officer of health to have the discretion to use this new power." That isn't playing judge; that's exercising

the same discretion you exercise when you make a determination that there are reasonable and probable grounds.

In that sense, I'm just wondering to what extent are your arguments, your legal arguments and your discretionary arguments—are they bolstered by or have they not yet been visited upon by the Ministry of the Attorney General?

Dr D'Cunha: I can respond to the area of medical expertise, because you clearly would also like to hear from the Ministry of the Attorney General and I won't attempt to practise law. Simply put, it puzzles me medically and from a public health standpoint how the taking of a blood sample, with results maybe a couple of hours in the coming depending on where the exposure happened and getting that blood sample to the appropriate lab for testing, would affect the appropriate clinical decision to be made then and there.

There is also the concept of a window period to be factored in, where an individual who's infected and capable of transmitting disease—and some of these have long incubation periods, where someone will test negative but actually be capable of transmitting the disease. Therefore, a negative test result is not significantly going to change the initial clinical management. The only value of doing the blood test, if you will, is getting a positive back to say so-and-so was such-and-such. Clinically, you make some clinical decisions on the spot before you even get to that stage. That's the real clinical significance.

And to assist that, you need baseline testing of the emergency services worker too. Let me give you a situation, for instance. If an emergency services worker is already HIV-positive, why would you want to offer that individual appropriate post-exposure prophylaxis? If the individual is—and this is where one needs to take a history—already appropriately immunized against hepatitis B, which has been offered to all emergency services workers in the province on a voluntary basis, and if one knows the results by titre, in the preceding two years of a protective titre, there's no further action. If the results are not known or not available in a timely fashion or if they're less than 10, then the person needs a booster, say, for hepatitis B.

Mr Bryant: I may have misunderstood, but isn't there a value in the person who may require treatment getting that information so they can then seek treatment?

1650

Dr D'Cunha: I don't believe the value is in the individual who is exposed. The value is probably in the personal care physician, the occupational health physician or whoever is providing health care to make the appropriate decisions. Respectfully, a layperson in possession of a test result is not likely to be able to interpret it in light of the circumstances, other than to say, "I was exposed to ABC and ABC tested positive for this disease." If anything, it has to be set up in a context, in an appropriate framework of counselling and an appropriate clinical plan of action, to deal with what one is dealing with.

Mr Bryant: But you said before, I thought, that time was of the essence. If time is of the essence, why not improve our regime so that we could respond quicker?

Dr D'Cunha: The blood testing is not an improvement of the regime, if you will. The blood testing is, in my view, a false sense of security, because you're relying purely on the blood test results, and it only has meaning if it's positive. If it's negative, unless you repeat that blood test over subsequent periods of time to determine whether that individual was in the window period or not clinically, even without blood test results, health care providers out there would do what is appropriate where the exposure was significant. When you step right back to the incident, it's an assessment of the exposure.

I'll use some simple examples to make the point. Did somebody get stuck with a needle on-site? Did somebody just see blood getting splashed with nothing coming on the individual? Did someone's clothes just get wet? Was that someone donning appropriate protective equipment? That is why one of the things we recommend to all people is that when you're in a situation where you're providing first aid, generally follow the principles of universal precautions. From a prevention standpoint, which is what I believe in, I invest in universal precautions. This is kind of coming after the fact.

Mr Peter Kormos (Niagara Centre): I appreciate very much your doing this report. Is this the first time you've ever been consulted about the bill?

Dr D'Cunha: That's correct.

Mr Kormos: We are under time constraints. However, I ask committee members to consider that if the Chair's attention is not drawn to the clock, the committee has the capacity to go beyond 6 of the clock.

Very quickly, I'm trying to think of a scenario where—because I hear you about the protocol and I hear you about the fact that I can test negative for AIDS today yet a week from now test positive for AIDS. That's one of the things you've mentioned in terms of delayed response. I understand that. I presume that any emergency medical officer, any firefighter, any police officer, any good Samaritan who's getting medical advice is going to be cautioned in that regard, that the blood you get from me today may prove negative, but that doesn't mean for sure. But if it proves positive it's a pretty good indication, right?

I'm talking about a case where I'm in my basement and I'm on my table saw or my radial arm saw and I take however many digits off—more likely on the radial arm saw; they're far more dangerous than the table saw. But either my neighbour or a firefighter or whoever comes to my aid—there's blood all over the place. Wouldn't this bill at the very least give them access to the blood testing that would be done upon my arrival at the hospital? Do you know what I'm saying? My presumption is that if I'm at the hospital in an emergency room, even that firefighter, police officer or neighbour—you talk about using protocols. My neighbour is not a trained emergency medical person, but I hope my neighbour would dive in there, with bare hands if need be, to do what they had to

do. But wouldn't this bill give my neighbour access, for instance, to the blood testing done immediately when I arrived at the hospital—this bill—in terms of the medical officer of health determining, "Yes, neighbour, good Samaritan, you're entitled to a sample of his blood."

I understand what you're saying about the protocol. I understand what you're saying about the public health issue, which is different, because public health is different from private health issues, very clearly. But if this exists either to put people at ease or to permit them—it may not be every case where it permits the rapid response that was spoken of, within two hours for some exposures, that you need to blast it with whatever chemicals or medical response within two hours, but it may accommodate some. That's what I'm putting to you: does it have that capacity?

Dr D'Cunha: I would put to you that under the existing protocol, if somebody was significantly exposed—and the existing protocol does cover good Samaritans—a determination would be made by the health care provider and public health whether there was or was not a significant exposure. If there was a significant exposure, the appropriate intervention would be considered, for example, in the case of hepatitis B, the provision of the appropriate immunoglobulin and hepatitis B immunization if the exposed person was not immunized, and in the case of HIV/AIDS that would happen.

While all of this is going on on this front, the health care provider providing care to the subject, if you will, would take somebody through a whole discussion on informed consent. In particular, the standard of medical practice in Canada today, as advocated by the Canadian Medical Association and that I hope all my medical colleagues are following, is that before you test somebody for HIV/AIDS you take them through an informed consent process. Generally, when you sit down in a reasonable manner and discuss with an individual who is able to give consent—because in certain situations, if they've lost a lot of blood, they may be unconscious—in fact consent is readily given. So that happens. This is, in my view, an unnecessary intrusion, because I have not seen evidence of this failing. This is a false sense of security, if you will.

Mr Kormos: You say there have been no cases. I can vouch for one case of a police officer in my community, with whom my office worked closely, who, if I recall accurately, was bitten—it was a real bite—and did contract one of the hepatitises—I don't have the details—as a result of that. It was only when that police officer was tested that it was revealed; it wasn't as a result of the biter, the person committing the assault, being tested. There's one case. I don't know personally of any others, but I'm saying that I know of one case. My office worked with this regrettably young police officer. I don't know if this bill would have necessarily facilitated speedier treatment. I don't know. But this bill doesn't detract from the existing protocol, does it?

Dr D'Cunha: It does not detract from the existing protocol. If anything, it requires an intrusive invasion into somebody's body—and I'm going to stay away from the legal jargon—by sticking a needle in, when in fact you go through the other process and still get to where you want to go.

In terms of the unfortunate police officer who may have contracted one of the hepatitises through this occupational exposure, I am extremely concerned, if there's truth to that story, as to why the system didn't hear about it. This is the kind of thing that—

Mr Kormos: That's interesting, because we were dealing with, effectively, workers' comp. We were dealing within the system. I'm telling you the straight goods, and I'm not going to say anything more about it, but we were dealing with all the provincial authorities. I'm not stringing you a line. I'm giving you the straight goods on that one.

I'm going to yield the floor, because we've got to speed up.

Mr Garfield Dunlop (Simcoe North): Doctor, thank you very much for coming this evening. I just want to clarify a couple of things, first of all the timing. It's unfortunate that you hadn't heard about this bill before. We had discussions prior to even September 11, so I don't want to hang anything on September 11, feeling sorry for police officers or firemen or anything like that, because we had quite a bit of consultation on this particular bill during the summer months. At that point we were dealing with medical records but changed the bill to blood sampling. We've notified a number of ministries, including the Ministry of Health and the Ministry of the Attorney General. I have an opinion from the Ministry of the Attorney General as well. By the way, I'm the one who drafted the bill. Business services, correctional services, the Solicitor General—all these ministries had an opportunity to see this bill.

Many of the people we visited with have your bill from 1994, an information manual for officers. However, I've got to tell you, if you think this is working, it's not, because the people who presented me with copies of these said it's not good enough. There are too many officers, too many firemen—and I can tell you some of the people we talked to: paramedics, for example. I had one paramedic who had been openly cut 35 times in his 15-year career, providing a service to the public. We talked to police officers—one police organization, the Police Association of Ontario, represents around 14,000 police officers—firefighters from across our province, correctional workers, victims of crime and just good Samaritans, and even, recently, ski patrol workers, the Canadian Ski Association, the people who provide first aid on the hills. They are very, very concerned about what's taking place, the kinds of diseases they can come across.

1700

We felt that this bill promoted protection and worked with public health. We believe it helps prevent the spread of disease when you can take a blood sample and find out what person may or may not have a communicable dis-

ease and treat them for that. So we think that at times it actually prevents the spread of disease.

I take it that you're not in favour of the legislation before you. I assume you have no amendment to it either. Today, we've only had one amendment come in, and that was from the Office for Victims of Crime.

I wanted to make those comments to you. We did have a response back from the House here. We have met at times with the privacy commissioner, and there's no response today from her. We've got that in writing, that she's not responding to this bill at this time. We felt that the bill, even in its current form—the three parties in the Legislature support the bill. We felt it was certainly a step in the right direction.

The problem we have right now, as we sit here today, is that we have clause-by-clause to complete today. We have no amendments, so we have to either go back to the House and ask for more time—but under the order we're working with today, we have to finish clause-by-clause and then report to the House, and then that report may have to go back to another set of hearings or more amendments, whatever it may be. I wanted you to know that part today. I really do apologize that you haven't seen this up until this point, because it certainly has been circulated to your ministry.

Dr D'Cunha: With your permission, two points. It's fair for me to state, and legal counsel advised me, that an earlier version of your bill did come to the ministry, and similar flags were raised then. I noted from your comments that I didn't hear a single public health association named. In discussion last night with the medical officers of health, who fortuitously—some of them are in the audience—happened to be in town for two days for a meeting, none of them were consulted, and they're all unanimous about this. I'm astounded and amazed, respectfully, that a bill is being put under the HPPA and public health groups were not touched base with. I'm still kind of reeling from that observation on your part. I respectfully put that in front of you.

Ms Marilyn Mushinski (Scarborough Centre): Like Mrs McLeod, Dr D'Cunha, I was not aware of all the protocols that existed within the Health Protection and Promotion Act, and like my colleague Mr Dunlop, I'm not entirely convinced they're 100% effective. I'd like to tell you why. This is particularly topical for a constituent of mine who was in my office just a couple of weeks ago, who has not received any satisfaction from either his employer or his union with respect to an incident at work. He was bitten by a robber. While it is not appropriate, obviously, for me to go into all the details with respect to this individual, the system did break down in that he was a victim of crime but the accused criminal was let go by the police before there was any opportunity for any protocols to be put in place. I'm not even sure at this point that either employers, unions or the police were aware of these particular protocols.

Can you tell me how Bill 105 would detract from those protocols, given that we are specifically talking about a group of individuals here who become victims of crime?

If I may, just to carry on a little bit, this particular constituent of mine, who was bitten about five years ago, is more afraid of having contracted a disease that is not immediately identifiable. The impact this has had on his family—his relations with his wife have moved to the point where he no longer has any relations with his wife. So there are implications of a number of criminal activities, if these protocols are not put in place, that have a serious impact on the lives of innocent victims of crime.

I'd like you to respond to how you feel Bill 105 would detract from that.

Dr D'Cunha: I'm going to answer your question in a slightly different manner. The stated intent, save for the good Samaritan and the victims of crime, is predominantly an occupational health and safety issue. With reference to the specific issue you raised as it pertains to a constituent of yours, any member of the public should have contacted the local health department to discuss the potential exposure, get appropriate counselling and advice. If the individual did not contact the local health department or the local office in the new amalgamated Toronto, that is some cause for concern, because that is what public health is all about: to discuss potential exposures and get the appropriate response.

I'd like to stress again that this is predominantly an occupational health and safety issue, save for the good Samaritan or victims of crime piece, and this is the wrong statute you're seeking to amend if that is indeed the desire of the House.

Ms Mushinski: But if we're talking about protocols in terms of protecting everyone here, is there not some need for us to ensure, even under the Occupational Health and Safety Act, that those protocols apply to employees within a work environment? The criminal activity—this particular employee, finding a robber in the process of robbing an establishment, was bitten by that robber. There are two things that come into play here. All I'm saying is that I don't see how Bill 105 actually detracts from protecting victims of crime, whether they're in the workplace or outside of the workplace. The purpose here is to protect victims of crime, emergency services workers, who are also in the workplace, good Samaritans and other persons. So it really isn't one individual but a whole range of individuals who are victims of crime, or could be.

Dr D'Cunha: I would contend that the province has 17 mandatory public health programs that all 37 health units in the province are obliged to deliver. Within those 17, there is one program called control of infectious diseases, in which state-of-the-art science protocols have to be followed by the 37 health units on the ground. I'm proud to tell you they actually do that.

From what I am hearing, members of the committee, of the individual anecdotes you're tabling, if it appears there's a lack of knowledge, I don't see how a statute amendment is going to address that. You're still going to have to deal with the lack of knowledge. I contend to you

all, respectfully, that the means already exist through the control of infectious diseases program for anybody, regardless of whether it's a non-workplace setting or a workplace setting, to seek help. If it's a workplace setting, one potential route is the Occupational Health and Safety Act. Another potential route is the local public health department, which, where appropriate, will refer it to the Ministry of Labour. The statute in fact makes that clear, that where appropriate, the local medical officer of health will refer a matter to the ministry of the government of Ontario that has the primary role in the particular situation. In the case of the good Samaritan or the victim of crime, those persons wouldn't be picked up under occupational health and they would then stay predominantly in the public health realm.

That having been said, regularly there have been biting incidents in schools that public health has been actively involved in. I remember that during the two-week period in which I was serving out notice to come to my position, there was a situation in public health that was being dealt with in an unnamed health department involving a known HIV-positive child having bitten somebody. The situation was handled with dignity, appropriately, without invasive tests being carried out on the subject, on the applicant, to the satisfactory resolution of all concerned.

1710

Ms Mushinski: I'm not arguing the effectiveness of the protocol. My concern is, what happens when that breaks down? We can use anecdotal examples because that's what we're here for, just to really protect the interests of our constituents who have been impacted by a protocol that broke down. Whether it was in the workplace or outside of the workplace, I believe we should be doing things to strengthen protocols that actually help protect all victims of crime. If that means extending your protocols into the workplace, and Bill 105 attempts to achieve that to some degree, then I think that's a good thing rather than a bad thing.

Dr D'Cunha: And I would contend that because the control of infectious diseases standards have the force of law, because they've been signed by the Minister of Health, you already have that statute re protection built in. If it's the wish of the House to enact five pieces of legislation to say the same thing, that's the desire of the House.

Ms Mushinski: God forbid, but thank you for your comments anyway.

The Chair: Ms McLeod, a brief comment?

Mrs McLeod: More a suggestion in terms of moving on with the task before the committee, Mr Chair. Obviously, I think it's fair to say that the government didn't perhaps take private members' bills seriously enough to have put in place the standard check-and-balance system that a government bill would go through. The government is perhaps a little bit caught here at not having responded in due time, even though this particular piece of private member's legislation was put forward by one its own members.

I was one who suggested that Dr D'Cunha be present here because we were hearing concerns from medical officers of health. I guess my hope was that there might be some recommendation for specific amendments that could be quickly incorporated, and that's not the case. In the meantime, we have a bill before us that has received unanimous support in the Legislature, if I am correct, and we have a time allocation motion that takes it back to the House immediately.

My suggestion is that in the absence of specific amendments, as Mr Dunlop has noted, apart from the one from the Office for Victims of Crime, there section 3 provides a new section 97 in the HPPA. It is "The minister may make regulations," and section (c) of that is "governing an application for an order made under subsection 22.1(1)." That seems to me to be a very broad regulatory-making ability. I would normally be apoplectic about such broad regulatory-making ability being given to any minister, but in this case it seems to me that that may provide an opportunity for the Minister of Health to take what will be a bill that I believe will receive third reading and look at incorporation of the reconciliation with the protocols and some of the confidentiality issues in particular that need to be addressed for the minister to be comfortable with the bill and its consistency with the HPPA. If the committee feels that that regulatory ability is broad enough under that section, I would strongly recommend that those regulations be put in place before the bill is actually proclaimed.

Mr Kormos: I understand that there are two lawyers here from the Ministry of the Attorney General, one of whom is prepared to speak to this bill and its constitutionality. He has to leave, I'm told, at 5:30, so I'm hoping we can accommodate him.

The Chair: Do we have consent?

Mr Kormos: Who you gonna call at 3 am, huh? A lawyer.

The Chair: I see consent from this committee. Before we begin, I do wish to thank Dr D'Cunha and Ms Henderson for coming before the committee. Thank you very much.

MINISTRY OF THE ATTORNEY GENERAL

The Chair: Could we ask the people identified to come forward to the witness table? For the purposes of Hansard, could we ask for your names?

Mr William Bromm: I'm William Bromm, with the policy branch of the Ministry of the Attorney General. With me is Richard Stewart, and he's constitutional counsel with the Ministry of the Attorney General.

The Chair: Mr Kormos, did you have a question for the people at the witness table?

Mr Kormos: Yes. You're lawyers with the Ministry of the Attorney General, and you folks have reviewed this bill with a view to its constitutionality and its capacity to withstand constitutional tests, right?

Mr Richard Stewart: In a preliminary fashion, yes.

Mr Kormos: And have you examined the bill from the point of view of its application, in terms of its enforceability?

Mr Bromm: No, we didn't look at the interaction between the bill and the current provisions of the Health Protection and Promotion Act or how it would be enforced. We were asked on a very preliminary basis to look at the bill to see whether any constitutional issues came up and whether or not they were significant and what the risk was. But it was a preliminary review and it was quite limited in scope.

Mr Kormos: So you've got caveat after caveat here.

Mr Bromm: As most lawyers usually do, yes.

Mr Kormos: OK. Let's hear what you've got to say.

Ms Mushinski: Just one question.

Mr Kormos: I just asked a question.

Ms Mushinski: If a reg was developed to accomplish what it is that we want the bill to accomplish, you would, I take it, obviously be providing legal counsel in order to do that.

Mr Bromm: We could provide an opinion, and with our civil law division we could provide an opinion on the reg power. I would comment on a preliminary basis that I think the scope of the matters you wish to deal with through regulation probably isn't covered by the last clause, because it deals with the application procedure. One of the concerns that had been raised has to do with the confidentiality of information after the application has been processed and approved and what you can do with that information, so I think you would need to extend your regulation-making authority before you could deal with certain issues, but you could do it.

Mrs McLeod: That is when the confidentiality provisions become a concern, after the order has been made. It's a question of what binds the recipient of any information that comes from the testing. Are you saying that clause (c) does not provide the regulatory scope to make that clear?

Mr Bromm: Yes. If you look at the wording of that section, it says, "governing an application for an order," so the regulation power has to do with the procedure you follow when you make an application but it wouldn't extend to the authority to deal with information that results from an order to actually produce a sample. You would need a new regulation-making power to do that.

Mrs McLeod: You wouldn't be able to suggest one very quickly to us, would you?

Mr Bromm: If you want one, we could probably speak with legislative counsel about what it might look like to have as broad a scope as possible. But a lot of times there's hesitation to have a completely open regulation-making authority, so it would be better to know exactly what types of issues you would like to deal with in the regulation. I think legislative counsel would be more comfortable to know the parameters. All I know, hearing what I heard today and looking at that power, is that it's not broad enough to deal with all the issues you would like to deal with through regulation.

Mr Kormos: Let's get to where we started, which is your comments on the constitutionality, please.

Mr Stewart: In brief, any time you require a person to submit to the mandatory taking of blood it does raise significant privacy issues under section 7 and section 8 of the charter, unreasonable search and seizure and potential violations of the security of the person. After a preliminary review of the proposed amendments, it's our view that the provisions are structured in such a way as to avoid excessive arbitrariness. They're specifically restricted to where there is a determination on reasonable and probable grounds that the applicant does fit within the prescribed criteria, thus limiting the circumstances in which blood would be taken to cases in which there are exigent circumstances that would justify the intrusion.

Mr Kormos: That's what's important. I read this and I also look to the federal bill that's going to be before Parliament, and it parallels this one significantly. One of the things I want everybody to be clear on: as I read what gives the health officer jurisdiction, the applicant may have become infected with a virus. That goes to the nature of the contact with the fluids, doesn't it?

Mr Stewart: Yes, and that's something that the medical officer reviewing the particular application would have to make a request about, as to whether there is a reasonable risk that would justify the taking of blood in that circumstance. He or she is using their expertise to make an assessment that the risk is reasonable in that circumstance to justify.

Mr Kormos: Because it very clearly says "a virus." It doesn't focus on any single communicable or viral communicable disease, right?

Mr Stewart: Right.

Mr Kormos: OK.

Mrs McLeod: This is a lousy way to make legislation, by the way. Nevertheless, we're in this position. The amendment process should have been completed by Friday at noon.

Given what you've just told us about the confidentiality provisions not being able to be addressed, would something like this expand the scope of the minister's regulatory power? I can't believe I'm talking about expanding the minister's regulatory power, but what about a clause (d) to add "the minister may make regulations setting out privacy provisions that apply in circumstances in which an order is made under the amended HPPA"?

Mr Bromm: The more specific you can be with respect to the issue you want to deal with, obviously, that power would be better. But the Ministry of Health, in particular their privacy people, might want to have some time to think about what that power looks like and whether or not it's appropriate. The only comment I can make at this point is that the power that's currently there isn't broad enough to do what you want, and the committee needs to consider what it is they would like to do through regulation and then be as clear as possible. But I wouldn't want to comment on a health-related statute from the Attorney General's perspective, other

than to say those things, and then I would leave it to the Ministry of Health and legislative counsel to decide if that's an appropriate wording for the statute, given the other provisions of the health statutes. Sorry I'm not very helpful.

Mrs McLeod: No, no, that's all right. It's unfortunate the Ministry of Health missed the time frame in which to respond.

The Chair: If that concludes questions or comments for the gentlemen at the witness table, I'd like to thank—

Mr Kormos: Whoa. I have one more question. Your comments surprise me. I thought the Attorney General, as a lawyer, did all this drafting and legal crafting himself. You mean that's a myth?

Mr Bromm: Every now and then he lets someone else do a bill.

Mr Kormos: Thank God there are real lawyers like you at the Ministry of the Attorney General.

Mr Dunlop: Weren't you the AG for a while?

Mr Kormos: That would have been interesting.

The Chair: Excuse me, gentlemen, I have a further question or comment from legislative counsel.

Mr Michael Wood: I wanted to make one comment on this, perhaps also in response to a question that Mr Kormos just asked. In Bill 105, when it talks about, in section 97, a reg-making power, that is a power for the minister in the Health Protection and Promotion Act, which is the Minister of Health. So the regs would be drafted, in fact made, by the Ministry of Health.

Mr Stewart: Yes, and that's why I wouldn't want to comment from the Attorney General's perspective about what the power should look like, because it's a Minister of Health power and not an Attorney General power.

Mr Wood: Exactly.

The Chair: Thank you, Mr Stewart and Mr Bromm, for coming forward. This would now conclude the first agenda item. The next agenda item is clause-by-clause consideration of the bill.

Mr Kormos: Chair, I'm wondering if a three-minute recess might not be useful in organizing the balance of this committee.

Mr Dunlop: Would that be OK, Mr Chair? I'd like to do that as well, just a quick recess for a couple of minutes.

The Chair: We will return in five minutes.

The committee recessed from 1724 to 1746.

The Chair: Mr Kormos?

Mr Kormos: Chair, I just spoke with Mr Dunlop and Ms Ecker, and Mr Bryant was with us for most of that time, at least for the substantive part of the conversation. We have agreed, subject to people indicating so here—this is my understanding of the agreement—that because of the apparent need now for amendments that would be driven primarily, I presume, by the Ministry of Health, but it doesn't really matter who drives them in response to the concerns about the regulatory power, the bill needs some amendment satisfying those concerns. Unfortunately, the motion that was moved to get the bill here was so restrictive, unlike the one I prepared for Mr Dunlop, that it requires us to put the question on the bill at the end of today's hearings and to refer the bill back. That's the motion that was agreed to.

It would have been my preference for the bill simply to have remained in committee and then adjourn this over to when the committee meets next. I've indicated to Ms Ecker that we will accommodate Mr Dunlop in terms of agreeing to a special one-hour sitting of the committee or what have you. So what we propose to do today because of the nature of the motion is vote on the bill clause by clause so the bill can be reported back to the House. There will then be unanimous consent given tomorrow to the bill being referred back to committee so that the amendments being proposed can be put. Again, there will have to be some co-operation about making sure that the committee assembles itself. If it requires unanimous consent to sit outside of normal committee times, we've indicated that could be done. We're eager to see the bill proceed and we want the bill, as we've indicated, and as I'm sure Mr Dunlop and everybody else does, to do what it purports to do in an appropriate way. That is my understanding, and Mr Dunlop can comment to that.

Mrs McLeod: First of all, a question, Mr Chair: explain to me how we proceed at the end of this day in terms of the resolution that says the question on the bill must be put in committee. We don't have a resolution from the House to change that at this point.

Mr Dunlop: We go through this bill today, so there are no amendments whatsoever to it, and report that to the House tomorrow.

Mrs McLeod: And we pass the bill unamended?

Mr Dunlop: We pass the bill unamended—

Mrs McLeod: Then how can it come back for future amendments?

Mr Dunlop: By unanimous consent in the House to go back for more amendments.

Mrs McLeod: All right.

Mr Dunlop: This is what Mr Prins mentioned to be me earlier in the day when I first saw the problems that had risen from the MOH.

Mrs McLeod: Mr Chair, I guess we take on faith that the intent is still to pass the bill, even though I think there is some discomfort for the government in the presentation they heard this afternoon. It's the wish of members of this committee certainly and members of our caucus that this bill be passed. I trust it will be possible to bring this bill back to committee and deal with those proposed amendments before the conclusion of this House, which is potentially next Thursday.

Mr Dunlop: That's the intent right now, Mrs McLeod. The government House leader's office will work with Minister Ecker to draft that motion.

Mrs McLeod: I'm prepared to accept that, but I would like to place an amendment on the table. My concern with going through with it unamended is that I really do believe the confidentiality issue needs to addressed. It makes me somewhat uncomfortable to pass the bill unamended in the expectation it's going to come back with amendments. I would have preferred at least to

have placed the amendment giving the minister the power to make regulations regarding confidentiality, which would address a key concern, prior to having a vote on the bill.

Mr Kormos: We can't prevent her from doing that. That's her right.

The Chair: And we'd we vote on it.

Mr Bryant: I also believe we ought to and I will put an amendment on the table, further to the submission from the Office for Victims of Crime, dealing with section 22.1(1). In other words, I don't want to just vote for a provision that I don't in fact support.

Mr Dunlop: All right. We'll do the two today. There's no problem with that.

Mrs McLeod: They can be changed if for some reason they don't seem to be adequate. We can have that discussion when it comes back.

Mr Dunlop: They can be changed, yes.

Mr Kormos: Furthermore, I would ask, and I've spoken with Mr Dunlop, that for 22.1(1)(a)(i) the government consider amendments to that portion where it says "as a result of suffering a physical injury while being the victim of a crime." That's what's dealt with in the amendment, to make (ii) the parallel of that.

Interjection.

Mr Kormos: Is this addressing (ii)? It currently reads "while providing emergency health care services or emergency first aid to the person, if the person is ill, injured or unconscious as a result of an accident or other emergency." I'm going to suggest that to make that the parallel of the amended (i), the amendment Mr Bryant is proposing, the government consider deleting the words reading "if the person is ill, injured or unconscious as a result of an accident or other emergency." That seems to me to be incredibly restrictive in the same way that suffering a physical injury while being the victim of crime was considered restrictive. Do you understand? It's my view that sections should parallel each other. Do you understand what I'm saying, Mr Dunlop, the deletion of the words "if the person is ill, injured or unconscious as a result of an accident or other emergency"? It seems to me that the paragraph should read, "while providing emergency health care services or emergency first aid to the person," end of paragraph.

Ms Mushinski: Are you talking about 22.1(1)?

Mr Kormos: Section 22.1(1)(a)(ii).

The Chair: Let's formalize the process and begin clause-by-clause consideration of the bill. You may recall the standard question, are there any comments, questions or amendments to any section of the bill, and if so, to which section? If the committee is amenable to this, we could begin with section 1.

Mr Dunlop: Go with section 1.

Mr Bryant: I move that subclause 22.1(1)(a)(i) of the Health Protection and Promotion Act, as set out in section 1 of the bill, be struck out and the following substituted:

"(i) as a result of being the victim of a crime,"

The Chair: We have a Liberal motion to section 1. Shall this amendment carry? Carried. It's unanimous.

Mrs McLeod: Conscious of the fact that we have a vote, we can move really quickly here, folks.

The Chair: Next question: shall section 1—

Mr Kormos: As amended, carry?

Interjections: Carried.

Mr Kormos: Section 2, carried?

Mrs McLeod: Would you like to compress the next sections, Mr Chair, right up to section 3? Actually, section 2 is—

Mr Kormos: Shall section 1 carry? Carried. Section 2, carried?

The Chair: Yes, section 1 carried. Shall we collapse sections 2 through—

Mrs McLeod: It's just section 2.

Mr Kormos: It's just section 2. It's on page 3 of the bill.

The Chair: I'd better get order here.

Are there any amendments to section 2?

Mr Kormos: No, section 2 is carried.

The Chair: Shall section 2 carry? Carried.

Section 3, any amendments?

Mrs McLeod: I move that section 97 of the Health Protection and Promotion Act, as set out in section 3 of the bill, be amended by adding the following clause, and this is under the heading "Minister may make regulations":

"(d) specifying restrictions or conditions on the use or disclosure that any person may make of the sample of blood described in clause 22.1(2)(b) and on the use or disclosure of any information derived from the sample of blood."

This is the suggested wording from leg counsel. It just allows the minister to make confidentiality provisions.

The Chair: Any further discussion? Shall I put the question?

Mr Kormos: Carried.

The Chair: Shall the Liberal amendment to section 3 carry? Carried. Shall section 3—

Mr Kormos: Shall the section, as amended, carry?

The Chair: I'll have to repeat it; people didn't hear me. Shall section 3, as amended, carry? Carried.

Mr Kormos: OK, doing 4 and 5 together, please.

The Chair: In keeping with protocol, we will collapse sections 4 and 5. Shall sections 4 and 5 carry? Carried.

Shall the long title of the bill carry? Carried.

Shall Bill 105, as amended, carry? Carried.

Here's the last question: shall I report the bill, as amended, to the House? Carried. You're sure you want me to do that after today?

Meeting adjourned.

The committee adjourned at 1757.

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