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Mercredi 2 mars 2005

Standing committee on justice policy

Mandatory Gunshot Wounds Reporting Act, 2005

Comité permanent de la justice

Loi de 2005 sur la déclaration obligatoire des blessures par balle

Chair: Shafiq Qaadri
Clerk: Katch Koch

Président : Shafiq Qaadri
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON JUSTICE POLICY

COMITÉ PERMANENT DE LA JUSTICE

Wednesday 2 March 2005

Mercredi 2 mars 2005

The committee met at 1104 in room 228.

MANDATORY GUNSHOT WOUNDS REPORTING ACT, 2005

LOI DE 2005 SUR LA DÉCLARATION OBLIGATOIRE DES BLESSURES PAR BALLE

Consideration of Bill 110, An Act to require the disclosure of information to police respecting persons being treated for gunshot wounds / Projet de loi 110, Loi exigeant la divulgation à la police de renseignements en ce qui concerne les personnes traitées pour blessure par balle.

The Chair (Mr. Shafiq Qaadri): I'd like to call the meeting of the standing committee on justice policy to order. As you know, we're here to deliberate on Bill 110, An Act to require the disclosure of information to police respecting persons being treated for gunshot wounds.

SUBCOMMITTEE REPORT

The Chair: May I respectfully call for the subcommittee report.

Mrs. Liz Sandals (Guelph–Wellington): I would be happy to move the subcommittee report. It's attached; it's here at the end. I think the relevant piece for committee members to note is: "(8) That the research officer provide a summary of testimonies by Friday, March 4, 2005." In terms of committee members' work, the deadline for submitting amendments will be Monday, March 7 at 4, and we will be doing clause-by-clause the morning of March 9. I would move the report, as printed.

The Chair: Mrs. Sandals, I'm advised that you need to read the entire report into the record for posterity.

Mrs. Sandals: I need to read the entire report? OK, I can do that.

"Your subcommittee on committee business met on Monday, February 21, 2005, and recommends the following with respect to Bill 110, An Act to require the disclosure of information to police respecting persons being treated for gunshot wounds:

"(1) That the committee meet for the purpose of holding public hearings in Toronto on Wednesday, March 2 and Thursday, March 3, 2005, from 9 a.m. to noon;

"(2) That the following groups be invited to appear:

"—Canadian Union of Public Employees;

"—Ontario Association of Chiefs of Police;

"—Ontario Medical Association;

"—Ontario Public Service Employees Union;

"—Police Association of Ontario;

"—the College of Physicians and Surgeons of Ontario;

"(3) That teleconferencing/videoconferencing technology be used if approved by the subcommittee on an ad hoc basis;

"(4) That the clerk of the committee, with the authority of the Chair, post information regarding the hearings on the Ontario Parliamentary Channel and on the Internet;

"(5) That the deadline for receipt of requests to appear be Tuesday, March 1, 2005, at 5 p.m.;

"(6) That the length of presentation for witnesses be 20 minutes for groups and 15 minutes for individuals;

"(7) That the clerk of the committee, in consultation with the Chair, be authorized to schedule all interested presenters on a first-come, first-served basis;

"(8) That the research officer provide a summary of testimonies by Friday, March 4, 2005;

"(9) That the deadline for written submissions be Thursday, March 3, 2005, at noon;

"(10) That the deadline for submitting amendments be Monday, March 7, 2005, at 4 p.m.;

"(11) That clause-by-clause consideration of the bill be tentatively scheduled for Wednesday, March 9, 2005;

"(12) That the clerk of the committee, in consultation with the Chair, be authorized prior to the adoption of the report of the subcommittee to commence making any preliminary arrangements to facilitate the committee's proceedings."

The Chair: Any further comments or debate? May I call for an adoption of the report by the subcommittee? Any opposed? Carried.

I'd now like to invite to the committee the first presenter of the day, Mr. Tim Hadwen. Do we have Mr. Tim Hadwen in the room? We do not.

Mr. Robert W. Runciman (Leeds-Grenville): Mr. Chairman, I'm not a member of the committee, as you know. It's my first look at the report of the subcommittee. I think what might be helpful in the deliberations, as well—you may want to consider this as you proceed—is to ask for the views of your new deputy minister, Mr. Fantino, with respect to this issue and the legislation, prior to making recommendations to the

assembly. He's now a member of the public service in Ontario, and I think his views would be very helpful to reaching recommendations. I would encourage that.

The Chair: It's my understanding that if the committee wishes to do so, we can issue a formal invitation, but I'll leave that to you to decide.

Mrs. Sandals: I've got no objection to the suggestion, except for the technical one that he's actually in Israel. I'm not sure when we might arrange for him to appear, given the motion we just adopted.

Mr. Runciman: I think, with modern technology, he could submit it in writing via e-mail. At least you would have it for consideration. He has significant experience with these challenges.

The Chair: Do I take that as the will of the committee?

Mrs. Sandals: So we're suggesting that we would invite him to make a written submission if he wished to. Given that he's out of the country, that might not be possible, but we could invite him to make a written submission if he wished to.

Mr. Peter Kormos (Niagara Centre): Let's not be naive. When the minister makes a submission, he doesn't sit down late at night on his PC, typing it out himself. There's high-priced staff that, if the minister wants to make a submission, will manage to write it for him, just as they would under any other circumstance.

Mr. Runciman: It's not the minister; it's the deputy.

Mr. Kormos: The deputy, any of those people.

The Chair: May I ask for a formal vote on Mr. Runciman's suggestion? Would those who are in favour of asking our new emergency commissioner, Julian Fantino, to make either an appearance or a written submission to this committee please raise their hand. Any opposed? I will direct the clerk to execute that.

Is Mr. Tim Hadwen in the room?

I'm advised by the clerk that due to the demonstration at the front of Queen's Park, there may be some difficulties with regard to access to the building. So with your indulgence, I will ask for a committee recess for about 10 minutes, till about 11:20, when we may be able to track our two witnesses down.

Mrs. Sandals: Just a question, if I may. Has security been given the list of witnesses we're expecting, to minimize the hassle if they actually get to the door?

The Clerk of the Committee (Mr. Katch Koch): It's been posted, and usually we send out to the various services around the building the names of people who will be appearing before the committee on a certain day.

Mrs. Sandals: So security would have those names, so that they don't get any hassle if they do get to the door?

The Clerk of the Committee: They should be aware of it, yes.

Mrs. Sandals: Getting to the door might be a hassle.

The Chair: The committee stands adjourned till 11:20.

The committee recessed from 1112 to 1122.

ST. MICHAEL'S HOSPITAL

The Chair: Ladies and gentlemen, I'd like to welcome you back to the standing committee on justice policy. We will now proceed to our first committee witnesses of the day.

Before beginning, I'd once again like to ask if Mr. Tim Hadwen of OPSEU is in the room.

If not, I'd now like to welcome our second scheduled presenter, Dr. Daniel Cass, chief of emergency medicine at St. Michael's Hospital and classmate from way back when. Dr. Cass, if you could introduce yourself by name for Hansard recording purposes. I understand that you've brought a PowerPoint presentation as well.

Dr. Dan Cass: I have.

The Chair: Dr Cass, just to inform you, you have approximately 20 minutes in which to offer your remarks. Should you leave any time at the end, we will divide that time equally amongst the three parties for any questions and/or cross-examination.

Dr. Cass: Thank you very much, Mr. Chair. My name is Dr. Dan Cass. I'm chief of emergency medicine at St. Michael's Hospital, and I'm pleased to have the opportunity to present to the standing committee today. I'll also introduce Mr. Jim O'Neill, the director of the inner-city health program at St. Michael's Hospital, as well. Jim has joined me today, although I'll be doing the presenting.

I appreciate the opportunity to address the committee today regarding Bill 110. I'd like to offer another perspective on some of the issues surrounding mandatory reporting. The perspective that I bring is from an inner-city practice in emergency medicine in an inner-city hospital.

By way of overview, I want to give a bit of background on how this submission came to be, address a couple of specific issues on the bill itself and then spend the bulk of the next 15 minutes or so talking about some of the pros and cons of mandatory reporting, and perhaps giving a different perspective on some of the issues. I'll finish off with some recommendations.

By way of background to this submission, St. Michael's Hospital, for those who are not familiar with the institution, was founded in 1892 by the Sisters of St. Joseph. Its mission at that time and now was to care for the poor and the sick in the inner city of Toronto. It provides care for some of the most marginalized populations in Toronto. Mandatory reporting in this particular environment has the potential to negatively impact the relationship between clinicians and their patients, perhaps more so and in a different way in this environment than in many other institutions.

Prior to being presented to you today, this position paper that you've just received was prepared by Dr. Phillip Berger, who's the chief of family community medicine—many of you know him from his work in the inner-city health area—myself—and with some input from Dr. Michael Falk. Dr. Falk is a pediatrician at St. Michael's, but he also has spent an extensive part of

his career in inner-city Los Angeles and has dealt with youth violence, and that's his area of specialty.

This position that I'm about to present was endorsed by the medical advisory committee at St. Michael's Hospital, which is constituted of the medical leadership and the community advisory committee of the board of directors of the hospital. Unfortunately, due to the timing of these presentations and of our meeting cycle for the board, this has not been formally presented to our board of directors. That will happen this coming Tuesday, March 8. I wanted to stress that we've brought this forward with the consultation as stated, but not with the final approval of the board at this phase.

The recommendations that I'm going to start and end with today are the following: first of all, that we would oppose the mandatory disclosure of the identity of gunshot wound victims, as proposed under Bill 110, but then, in fact, that we would support the mandatory reporting of statistics regarding all gunshot wound patients that are treated, without patient identifiers, to an appropriate agency. I'll go through this and the background in some detail.

A couple of background points. I feel a bit like I'm preaching to the choir in this room talking about how Bill 110 came to be, but I wanted to focus on one aspect of what led up to this. Obviously there have been a lot of public and media perceptions about gun violence and changes in the frequency of gun violence. There's been advocacy from law enforcement leadership, such as Chief Fantino in Toronto and, more broadly, the Ontario Association of Chiefs of Police. Finally, the OMA section on emergency medicine gave this a large profile with some of their work.

There was a sentinel case at Mount Sinai Hospital. I have to point out that Mount Sinai is not a trauma centre, they're not a centre that sees many gunshot patients, but, for whatever reason, a patient presented there a few years ago with a gunshot wound. Police were not involved initially, but knew of the incident and arrived at the emergency department. I think that's important, because Bill 110 is focusing a lot on notifying police and involving them. Police were involved in this case, as they are in almost every case of gunshot wound violence in the city that we're aware of. There was a request for information and the patient declined to identify themselves etc. There was a lot of to and fro with the administration and the hospital lawyers, and the decision was that there was no provision to allow them to disclose information to the police, and it led to frustration on all sides.

The emergency chief also sits on the emergency medicine executive for the OMA. A survey was conducted and less than a third of the members responded. Most had treated very few gunshot wounds. In fact, only 17% had ever treated more than 10 gunshot wound patients in their entire career. But in that segment of the population that responded, three quarters supported mandatory reporting. Ultimately, this was adopted by the emergency medical section and the OMA as a whole.

Subsequently, there has been a lot written in the lay press and the scientific journals regarding both sides of the issue, including significant opposition from a lot of clinicians, including emergency physicians. The College of Nurses of Ontario has come out in opposition to Bill 110.

I want to highlight a couple of specific points and then I want to move into the pros and cons a bit.

The specifics of Bill 110 require reporting for patients treated at acute care hospitals but not family physicians' offices and not free-standing walk-in clinics, and this is an issue. It has the potential to encourage patients to seek care for gunshot wounds at inappropriate facilities. I'm going to come back to that.

Another aspect in terms of the specifics of the wording of the bill is that it's left vague in terms of who is expected to do the reporting. Is it a clinician? Is it an administrator? The wording states that it is to be done as soon as reasonably practical to do so without compromising patient care. However, one would imply that if it's meant to be in a very timely, real-time way, this would involve the clinician rather than the administrator, who tends to be working more in a Monday-to-Friday, 9-to-5 environment. So the question is, does that place clinicians in a conflict-of-interest position?

The pros and cons of mandatory reporting: The basic tenet underlying all of this discussion is that clinicians and hospital administrators don't release patients' information to anyone, and that there are exceptions to this for very specific circumstances. None of these currently involve reporting directly to the police. If you look at the mandatory reporting requirements in the province of Ontario at the moment, as shown here, you'll notice in the right-hand column that none of these involve any reporting directly to police. There may be agencies that submit information after further discussion and further review to the police, but there's nothing that reports directly to the police, as it stands now. So this is a significant change in the dynamic that would occur.

As health care providers and as a society, I think we universally hold that there has to be a very high threshold for violating that confidentiality that exists. That threshold really has to be breached only to ensure the safety of the patient or of others.

1130

The arguments in support of mandatory reporting are basically twofold: One is protection of the public, and the other is prevention via a public health role, the tenet being that the more we know about the causes and the incidence of gunshot wounds, the more proactive we can be about prevention. I think there's some validity to that, which I'll come back to.

Our position is that gunshot wound reporting does not meet the necessary standard to breach that confidentiality. It doesn't increase public safety, there's a significant downside to reporting, and you can fulfill that desired public health role very effectively without resorting to a mandatory reporting structure. I'll go through this in a bit.

In terms of the unnecessary nature of mandatory reporting, duty-to-warn provisions exist currently in the

common law. Right now, if we are treating an individual and we feel that the public is at risk from that individual, we are allowed to go to the police. There's common-law legislation in both Canada and the States to support this; professional colleges, such as the College of Physicians and Surgeons of Ontario, have this as policy. Most recently, in the PHIPA legislation, subsection 40(1) indicates that this information can be disclosed if there are reasonable grounds that disclosure is necessary for eliminating risk to others. So there are already provisions to do this without requiring Bill 110.

Secondly, the police are involved in most cases. In the vast majority of instances, whether it's through the 911 tiered-response process that occurs or through word of mouth, the police are almost always involved in these cases. Having worked in a trauma centre for 11 and a half years, I cannot remember a single instance in which I treated someone with a gunshot wound where the police were not already involved.

If the police aren't involved and we approach people, most are willing to have the police involved. In those rare circumstances where someone's not willing to co-operate and they don't want the police involved, I would submit to you that disclosure to the police of their identity is unlikely to lead to any useful information from the victim. Probably more importantly, Bill 110 neither compels the patient, nor does it allow the health care provider, to give more information to participate in the investigation. It's simply the name.

It has the potential, paradoxically, to put the health care worker in a bit of a bind. Police say, "You're required under law to report to us. Tell us about this guy. He's not talking to us; you come talk to us." Well, we can't. There's no provision under here that allows or compels us to provide more information than simply their name and the fact that a shooting has occurred.

In terms of the effectiveness of mandatory reporting, it's already in place in a number of institutions. We need look no farther than the United States, where 48 of 50 states have this in place. It's never been shown to reduce rates of violent crime or weapons-related charges, or to increase success in investigations. It's never been shown to be effective for its prime purported purpose of improving public safety.

There are downsides. Hopefully, I've impressed upon you the lack of need for this legislation. Let me talk about some of the downsides.

First of all, there's the potential for victims to delay or avoid presentations to emergency departments. The current draft, as I mentioned, excludes physicians' offices and walk-in clinics.

There are parallels to this situation that occurred in the 1980s, when there was mandatory reporting and disclosure of patient information of HIV-infected people. There was a well-documented pattern in the city—indeed, throughout the province and the country—that people would refuse to seek care or would decline to have testing done because of the fear of what happened when that information was disclosed.

In terms of avoidance of care, there's actually some evidence that this happens. The Journal of Trauma in the year 2000 had an interview in the United States with convicts who had been shot in the course of criminal activities. They asked them if they had gone to the emergency department for care. In fact, 92% of those who had been shot went to the emergency department for care. If you think about that for a second, it means that 8% of them didn't. One in 12 people in this population group who had been shot didn't go to the emergency department because of fear of the involvement of police. I don't think we want a system where people are discouraged from seeking appropriate medical care for fear that the police will then descend upon them.

The second downside is that it puts patient trust at risk. There's a blurring of responsibilities: Is the clinician working on behalf of the patient, or are they working on behalf of the police? In our marginalized populations in the inner city, I think this is an even larger issue than the general population. There's a greater mistrust.

As evidence of that, Stephen Hwang, who is a researcher at our inner-city health research unit at St. Michael's, published last year a survey of 160 homeless men in Toronto. Nine percent reported they'd been assaulted by police within the past year. They were asked, "In an emergency, who would you turn to for assistance; who would you trust?" Some 92% said they would call paramedics. Only 69% would involve police. There's a perception—and I'm not here to argue whether it's real or imagined—in many of our marginalized population that involvement of the police has some negative connotations that may impact care.

The third downside is that of a slippery slope. The initial draft of Bill 110, I'll remind the members of this committee, included reporting of stab wounds; that was removed.

The Ontario Association of Chiefs of Police position statement in 2000, and reiterated since then, is that the government should enact legislation to permit health care professionals to disclose personal information of patients if there's reasonable grounds to believe a crime has been committed—a crime, any crime, not just violent crime.

There's a will out there to move this far beyond simply reporting gunshot wounds. So the premise is: today, gunshot wounds; tomorrow, what will it be? As a society, is this a direction we want to move in? Do you want to have mandatory reporting of domestic assault, bar fights, suspected criminal activity? Where do you put the line on this?

Some of the proponents of this legislation have said, "Well, a gun is an indiscriminate killing machine that in the hands of someone has the potential to harm innocent bystanders." I agree. I would submit to you, so does a car operated by an impaired driver, but as a society we do not mandate that physicians report impaired drivers to the police department. They report to the Ministry of Transportation if they feel there's a medical condition that impairs their ability to operate a motor vehicle, but there's nothing today that compels me or allows me to

call the police if we have a drunk driver in our trauma room. I'm only suggesting that we need to be consistent in what society's expectations are.

The final downside is that it may increase the risk to hospital personnel if a victim feels that their care provider has betrayed their confidence. There's potential for coercion and threats to staff: "You know, Doc, I know you're supposed to report this, but it would really be in your best interest if you didn't." We've heard phrases like that in other circumstances. Right now, we have the ability to not report in some circumstances.

In terms of the public health role, I think this is a really positive aspect of a mandatory reporting structure. There's some evidence that the more data you have about the issue, where the hot spots are, what neighbourhoods have a gun control problem, what groups in society have an issue, the better you can target community interventions to high-risk groups and high-risk areas. I absolutely support that. There's evidence from inner-city United States centres to support this statement.

The fact is, you can achieve all of this with non-nominal data. You can take off the patient identifiers and submit that information to a database for public health study without having to involve individual patient names. For example, right now trauma registries exist which do exactly that. If a patient comes in with a minor gunshot wound, they may not be included in a trauma registry, which is really for people with multiple injuries, but it would be very easy by extension of legislation to require the reporting of all gunshot wounds without the patient identifiers.

In conclusion, patient privacy and confidentiality, I think, is a basic tenet of health care. We accept that there are certain circumstances where we have to breach that confidentiality. It must be for the protection of the patient or the public in a meaningful way, it must not be indiscriminate, and it's usually not to the police.

Mandatory reporting of gunshot wounds, I would submit to this committee, does not meet the threshold to justify breaching the confidentiality. It's unnecessary, ineffective and has potential downsides. We can achieve the public health benefits by using non-nominal patient data.

The recommendations, again, where we started from: to oppose the mandatory disclosure of the identity of gunshot wound victims as per the current draft of Bill 110, but to support the mandatory reporting of statistics, without patient identifiers, for all gunshot wounds to an appropriate agency.

I would be happy to have any questions at this point from the committee. Thank you.

The Chair: Thank you, Dr. Cass. We have about four or five minutes, which we'll divide evenly, starting with the PC caucus.

Mr. Runciman: I think it's unfortunate, as I said at the outset, that we're not going to have anyone here as a sort of point/counterpoint, the chiefs' association, for example, who have been the main advocates of this kind of legislation. They're not able to appear, apparently.

I have to say to the witnesses that I certainly disagree with the point of view they've put forward here today. I can only say from my own experience as a justice minister for a number of years—I think the primary advocate for this was the chief of police in the city of Toronto and some of the challenges that his officers were confronted with with respect to individuals who had suffered gunshot wounds and the lack of co-operation from certain hospitals and the fact that they were only made aware of gunshot victims in their hospitals because a staff person, a nurse or whoever, quietly made the call to the police because the officials in charge at the hospital were not going to do so. They were very concerned and they had their conscience, if you will, with respect to this matter encourage them to make the call to the police, and when they arrived at the hospital, there was a refusal to co-operate in terms of even interviewing, let alone being provided with an identification of, an individual who may have been involved, and clearly was involved, in some sort of interaction with weapons.

1140

You mentioned the 48 of 50 US states. I think it would be nice to have some information with respect to the medical profession's views when virtually every state in the United States has some form of mandatory reporting. They also have some significant penalties, which this legislation doesn't appear to incorporate, including up to three years in prison, for example, and significant fines. The government, to their credit, isn't suggesting that sort of approach here. You could perhaps reference that.

Stab wounds: I'd like to know at some point about the number of stabbing incidents—maybe you don't compile those statistics currently—versus gunshot wounds that you're confronted with at St. Mike's.

The other element of this is the fact that you're making this presentation, and the board at St. Mike's has not yet—this is a community board made up of representatives of the community. Hopefully, in my view, they may have a different perspective on this. I think this is a sort of professional cover-your-ass approach. When someone has been involved in what is clearly an act of violence and perhaps is the perpetrator of an act of violence himself or herself, I personally see nothing wrong with there being some sort of moral and community obligation on the part of professionals to make sure the police in the community are aware of that and the presence of that individual in their facility or institution.

That's my view of the world, Mr. Chairman. I don't know if we have any time left.

The Chair: I think we need to move on to the NDP caucus. Dr Cass, maybe I'll just get Mr. Kormos's comments, and if you need to address the Tory comments, please do that. Mr. Kormos.

Mr. Kormos: Thank you, gentlemen. I, for one, welcome your comments, because I'm not about to give this government an easy ride on this legislation, or any other, for that matter.

I've read some of the data on the Legislative Assembly Web site: the reference to OMA and their

position and the counterpoint as well from within the OMA. First of all, the vast majority of gunshot deaths are suicides—that's what the data in that material told me—and a significant number of gunshot wounds presenting themselves to the hospitals are attempted suicides, which, folks, is no longer a crime.

My concern is that doctors will be forced to invoke police participation in an attempted suicide, for instance, without any discretion even when it's contrary, in their view, to the welfare of the patient. Police do what they've got to do. Police are not doctors or health professionals, and they know it as well as anybody.

What can you tell us about any concerns you might have about that observation that, first of all, the criminal gunshot wounds are the minority? Self-inflicted accidental and self-inflicted purposeful are, as I understand it, in the vast, vast majority. What do you say about the mental health perspective, which concerns me a great deal?

Dr. Cass: First of all, I would say you're absolutely correct in terms of the leading causes of gunshot wound victims presenting, the cause of their injury, that it's more likely accidental or self-inflicted than criminal to begin with. The second point I would make is that we rarely see people who have self-inflicted gunshot wounds from suicide attempts, only because the lethality in that method of suicide is between 85% and 90%. So the number of people who attempt—

Mr. Kormos: You're not aiming at a running victim.

Dr. Cass: Correct. So it doesn't happen often, but I share your concerns that the indiscriminate involvement of law enforcement with someone who is in a mental health crisis may not benefit anyone.

If I may, could I take a moment and respond to Mr. Runciman's comments as well?

The Chair: Please, very efficiently, Dr. Cass.

Dr. Cass: I will very efficiently do so, as you know, Dr. Qaadri.

First of all, I thank you for raising the points that you did, partly because you helped illustrate some of the issues that I had raised in terms of the downsides. The slippery slope is apparent all over the comments that you made, sir—your comments about the desire to have this so that staff can co-operate with the police and help them in their investigation. This legislation does not do that, and it's setting up the expectation with the police that that's what is going to happen, that they're going to walk in the door and clinicians will be able to give them whatever information about the medical chart they need.

I've been heavily involved for three years in discussions with Toronto Police Services—with Bill Blair, with the chief's office—trying to put together a format for disclosure of information, not on gunshot wound patients but on everyday patients who come in, and determining what can and cannot happen. We've had instances where the police in our institution have threatened to take our staff out in handcuffs if they didn't provide patient information to which they had no access.

This does not give them access to any information other than a name, I would submit to you, in all but a minimal handful—I'm talking a few; four or five instances—that I'm aware of in the entire city of Toronto. We presented this at our emergency medicine grand rounds, and out of the combined experience of a number of emergency physicians and emergency residents from all of the centres across Toronto, of whom I asked, "How many of you have been involved in a circumstance in your entire career where someone presented with a gunshot wound where the police were not already involved?" there were two individuals in that entire room who had ever had it happen once.

The Chair: Thank you, Dr. Cass. I'd move now to the government caucus.

Mrs. Sandals: A number of us have questions, but let me start with one. It seems to me, in what I'm hearing you say, that you're painting a picture of a busy hospital emergency department. You have somebody with a gunshot wound. You have the police, you have an argument between the physician, the clerical people and the nurses present and the police, and everybody is having an argument about who can do what.

This might, in fact, be useful legislation in terms of protecting the emergency physician, the nurses and the clerical staff, because it's quite clear in this legislation what the responsibility is. The facility is responsible for developing a protocol within the hospital, so something presumably negotiated within the hospital. The police will be notified as soon as is practical, with the name. In a busy hospital setting this would perhaps enable you to get on with the business of treating patients and make it clear what you are responsible for reporting, because this makes it quite clear what you are required to report. This would seem to me to be facilitating your work rather than interfering with your work. I'd like to hear you comment on this.

I would suggest that, as we move around the province, different situations present, but in your own particular situation this might actually clarify the situation and let you get on with your treatment.

Dr. Cass: I can appreciate the perspective. I don't think that's the reality, though, because the information that's being sought in those discussions or arguments, however you want to characterize them, is rarely the fact that a patient's there or their name. In almost every circumstance, they have that information; it's rare for them not to. Where the arguments set in is in how much more information we are allowed to give them.

I can understand that this would seem to clarify. It takes away a tiny part of the puzzle, but it opens the door to a whole bunch more. So there's nothing except in the negative. By interpreting that anything that's not in this bill they don't have rights to, which is not accepted by the police, may I add, in our discussions with them—the police accept that the name being disclosed is the scope of the bill. There still is not clarity. To this day, there isn't clarity on what else can and should be disclosed by health care workers to police, apart from the identity of a victim. So this will take care of the identity of the victim, which is hardly ever the issue.

Mrs. Sandals: So in terms of privacy, then, this isn't actually interfering with privacy in the sense that, in many cases, the information would already be available.

Mr. Brownell had a brief question.

The Chair: If I may, Mrs. Sandals, just move on, we are a bit behind on the schedule because we were delayed with our witnesses.

Dr. Cass and Mr. O'Neill, I'd like to thank you for your testimony today as well as your audiovisual support and the written materials you've brought with you today.

Dr. Cass: Thank you for the opportunity.

The Chair: I would now like to invite—yes, Mrs. Sandals?

Mrs. Sandals: Could we just have one follow-up piece of information, then? When you get the result of the board's decision, it would be helpful—

The Chair: I need unanimous consent for that.

Interjection.

The Chair: Fair enough.

Mr. Brownell: That was my question.

Mrs. Sandals: That was his question.

The Chair: Thank you once again.

Dr. Cass: I apologize for the sequencing of this and the fact that it has not gone to the board first, but we didn't want to miss the opportunity when a number of the duly constituted parts of the organization felt strongly about this.

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The Chair: I'd now like to invite Mr. Tim Hadwen.

Mr. Kormos: While these folks are seating themselves, I'd like to direct some matters to Ms. Drent of legislative research.

The first submission made reference to the opposition to this proposition by the College of Nurses. Could we get documentation of that? The first participants also spoke to the plethora—they didn't use that word—of news and scientific-journal types of articles around this. I know that on the OLA Web site, with the bill, there are some, but could we get a canvass of some of the prevalent ones, especially the ones that generate the debate, the point and counterpoint that has been referred to? Also, the reference to the observation that, in the vast majority of gunshot wounds, the police are already involved: Is there any data on this, or is that simply an observation that could be made?

The Chair: Thank you, Mr. Kormos; your suggestions and research requests have been noted.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION

The Chair: I'd now invite Mr. Tim Hadwen. Sir, please introduce yourself for Hansard recording purposes. I remind you as well that you have approximately 20 minutes in which to offer your remarks. Should you leave any time at the end, we'll distribute that evenly amongst the three parties for questions. Please begin.

Mr. Tim Hadwen: My name is Tim Hadwen. I am the general counsel with the Ontario Public Service Employees Union. We represent 100,000 government and public sector employees. Several thousand of those employees are health care professionals working in public hospitals and other facilities that would be covered by this act.

With me is Patty Rout, a lab technologist, who is the chair of our health care professionals division and the direct representative of the employees who work in these facilities. She has canvassed employees who are directly involved in the kinds of situations to which this act would apply, and will be bringing forward the concerns that they wish this committee to hear.

We're grateful for the attention of the committee. Each of us proposes to make a brief submission of about five minutes' duration, and then we would be happy to take questions.

I'll begin by turning the microphone over to Patty Rout.

Ms. Patty Rout: I am chair, as Tim said, of the OPSEU health council, representing around 40,000 health care workers in this province. We work in mental health, ambulance, community, long-term care and hospitals.

I represent the types of members you would see in emergency. We have ward clerks, RNs, RPNs, pathology assistants, morgue attendants and technologists. Many of these workers will be in the emergency area when a gunshot wound is brought to the facility. I've spoken to our members about the situation, and this is what they've said.

We are generally opposed to the legislation for the reasons you have just heard, and we have an additional concern. When a person presents at the emergency door, they will first be introduced to a ward clerk, then a nurse, maybe a security guard, eventually a doctor, technologists, maybe a chaplain, and possibly the pathology assistant or the pathologist. Under the privacy act, as professionals, we are unable to release any information to anyone regarding a patient without consent. Under the policies and procedures in hospitals, only doctors can release a report to anyone over the phone.

Assuming that this legislation will change the relationship of the confidentiality between the health care worker and the patient, who will be responsible for reporting the gunshot wound to the police?

My members feel that this is the responsibility of the doctor. There are currently policies and procedures in hospitals to deal with such things. For example, in pathology, when a wound from a gunshot is discovered at autopsy—and it does happen there sometimes—the attending pathologist is required to call the coroner, and they decide whether the police are called. It is not the pathology assistant and it is not the pathology secretary who makes the call. This is a requirement of the doctor, and we believe the responsibility should remain with them.

We have to worry about the safety of our workers in hospitals. If a gang member finds out that we have to report every gunshot incident to the police, what sort of

situation could evolve in the hospital? Will there be enough protection for the workers? We know now how limited security is in the hospital setting, and that will have to change. We are not sure why gunshot wounds that appear at doctors' offices are not required to be reported, and certainly are concerned about the effect this bill will have on our community health centres and our members, as, with the passing of this bill, that would likely be the place we will find gunshot wounds presenting themselves.

In summary, we believe the physician should make the call of a gunshot wound to the police. Failing that, we need policies set in place to protect the confidentiality of the worker. There should be no sort of retribution from the regulated colleges for disclosing this information, and tighter security measures will need to be put in place in our hospitals.

Mr. Hadwen: If I could just speak briefly to the bill, and then we'd be happy to take questions. We have three points. The first is that we disagree with the bill entirely for the reasons you've heard; the second is that the obligation should be on the doctor to make the disclosure; and the third is that, if other staff are involved, they need a form of informant protection.

Dealing with the issue of the obligation being on the doctor to make the disclosure, in our view there's no need to involve non-medical staff at all. A physician will have to make the determination that a gunshot wound has occurred; it's a diagnosis. The physician, having made the diagnosis and being involved in the incident, should make the report to the police. This has at least three benefits: It clarifies who the attending physician is, avoids hearsay and second-hand information, and ensures that the right people are speaking to each other.

The requirement that the physician report should be backed up by the requirement that the physician chart the reporting in the facility record. That way, if there's a subsequent inquiry, there's a record of who has made the report and whose responsibility it is to be able to provide clarification. The physician requirement and the physician charting requirement could both be dealt with, if necessary, by way of regulation, but should probably be spelled out in the bill itself.

If other staff are to have any chance of being involved in reporting, then the identity of that staff person should not be subject to release by the hospital or by the police. Both institutions need to be required to maintain confidentiality of the identity of the individual and not provide that information in response to any form of inquiry or legal process. Maintaining informant confidentiality is not new to the justice system; there are good reasons to do it, including preventing reprisals and encouraging people to perform their jobs without fear of retribution. The only possible exception with respect to the maintenance of confidentiality of the individual who might be involved in reporting would be a court order, and then the ability of the court to make such an order should be structured such that it should be only if necessary in the administration of justice, bearing in mind the desirability of maintaining informant confidentiality.

We ask that the bill be defeated in all its forms but, in the alternative, that the report be made by the attending physician and that the attending physician chart the report; and, in the alternative, that if others are to be involved, the police and the hospital maintain their confidentiality, and only a court order under certain strictures be able to release the name to the third party.

In our view, the bill should be defeated, but in the alternative, these kinds of changes are required to ensure that there is adequate protection and an adequate sense of protection for health care workers in these facilities. Thank you very much.

The Chair: Mr. Hadwen and Ms. Rout, we have about nine minutes left for questions, and we'll start with the NDP caucus.

Mr. Kormos: Thank you, folks. It was interesting, because I saw the segment of the OMA that advocated for this bill, but they didn't offer up their membership as being the people responsible for doing the reporting of names, I suspect because most doctors didn't look forward to cooling their heels in the Mimico provincial court hallway for days at a time, after they'd been subpoenaed around the issue, for instance, of whether or not the purported victim perceived it as a crime or, in fact, it was reported as a result of the statute. I wonder if doctors have contemplated that. The Mimico courtroom—if you haven't been down there in a while, take a visit, because it hasn't gotten any better in the last 15, 20 years—pretty gamy place.

I note that they didn't offer themselves up. I'm presuming—and I'd like the chance to ask somebody who maybe is right there; you might know, though, yourself—that when somebody comes to an emergency room, at an appropriate time, once you've got the medical matter in hand, if any one of the health professionals there thinks that person has been a victim of a crime—either a mugging, an assault, a shooting, a knifing, a beer hall brawl or a domestic abuse—health professionals at some point will say, "By the way, do you want us to call the police for you or do you want an opportunity to call the police?" Is that a reasonable interpretation?

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Ms. Rout: I would think so. When we see social workers in emerg and they get presented with situations that need the police to be informed, they certainly ask consent of the patient at that point and then they move forward.

Mr. Kormos: I'm interested as well in the implications of this bill, and especially the bill as part of the slippery slope that some people here appear to even advocate. They're slippery-slopists, I suppose, in terms of their ideology. Let's take the case of domestic violence—again, we're still grappling with developing the means of adequately responding to this—where a woman, beaten, may not want at that point the police to be involved, for any number of good reasons from her

perspective. If she's the victim of a gunshot wound, qualitatively she's still a victim and qualitatively still is subject to all of the apprehension and fears, and it seems to me that compulsory disclosure might put her at further risk. What's your view in that regard?

Mr. Hadwen: Yes, confidentiality is so beneficial to both sides in this relationship, people tell me. It's beneficial to the patient to feel free to express what their real concerns are and it's beneficial for the care provider to be able to establish an environment of confidence and also to be able to give direct, blunt and plain advice to the individual, both of them knowing that this is a confidential relationship. That has a lot of advantages in a lot of circumstances for a lot of different kinds of health care workers, being able to have that kind of relationship with the patient and to get on with doing the job that they're supposed to do for that person. Anything that corrodes that relationship is problematic, not only for doctors, but for other health care providers who have to establish rapport with people very quickly to do some specific task, perform some specific procedure—intubate, do a test, whatever it may be. You need to be able to have a quick rapport in a confidential relationship, and anything that prejudices that is an ongoing concern for health care workers.

The Chair: I'll now move to the government side. Mr. Delaney, please.

Mr. Bob Delaney (Mississauga West): Thank you very much, and also for your deputation. I'd like to explore in a couple of questions your concerns regarding retaliation from a wrongdoer if a line worker or, for example, a non-medical staffer should report a gunshot wound. Does the fear of possible threats supersede, in your mind, the benefit of getting guns off the street in the minds of those you represent?

Ms. Rout: I certainly believe, from the people I talk to who are, say, ward clerks in emergency, that they're very afraid that people will take retribution toward them by putting their name forward. They are afraid of that. From that point of view, they don't want to be part of the reporting process at all, and if that means there is a delay in dealing with the gunshot wound, then that probably would happen.

Mr. Delaney: Could you describe the basis for that fear, please?

Ms. Rout: I think just a general fear. I don't think we've had any formal threats. It's never come to that point, but I think it's just a feeling. I don't think we have any stats to actually base that on.

Mr. Delaney: How about if one spouse shoots another? Shouldn't that be reported?

Ms. Rout: I'm not saying that things shouldn't be reported. There are certainly times when things should be reported to the police. I just don't feel, and our members don't feel, that we're the ones who should be reporting it. There has to be consent given, and I think it should be coming from the establishment, whether it's the institution or the doctor. But it shouldn't be the health professional who's sitting there in the front line having to call the police as well. That's not our job and that's not part of our responsibility.

Mr. Delaney: So when you say there should be consent given, who should give that consent?

Ms. Rout: It should be the patient. That's how our colleges are set up. We can't disclose anything about a patient without patient consent.

Mr. Delaney: OK. Talk to me a little bit about the College of Nurses or other colleges, their feelings on the disclosure of the names of gunshot wound victims.

Mr. Hadwen: The particular concern that's being raised, just for a second, is that health care professionals don't want to be subject to complaints to the college that they've acted unprofessionally; in other words, that someone about whom this report is made will complain to the college that there's been a violation of confidentiality and the college will then proceed with a disciplinary investigation of the health care professional. That's a particular concern of health care professionals.

The Chair: The PC caucus, Mr. Runciman.

Mr. Runciman: I find it intriguing too, really along the lines of Mr. Delaney, what you're suggesting here. The counsel said that they'd prefer to see this bill defeated: "It should be defeated" is the exact quotation. "However, if that doesn't happen, this is the list of things we'd like to see occur in it."

I find it passing strange that you, as a professional body, feel that if someone had been engaged, for example, in a murder, in a homicide, and was wounded in the carrying out of that homicide and is in your hospital, you'd feel no obligation to the community or in terms of broader public safety with respect to a requirement to contact the police about that individual in your institution. I find that disturbing.

You've said that you want the bill defeated, but then you have other conditions, I guess, if this were confined, in terms of reporting responsibilities, to physicians. I looked at some of the examples provided by the researcher: 48 of 50 US states have mandatory reporting, and it ranges with respect to who's responsible. Some appear to be quite broad, but most seem to be confined to the physician and/or the manager or superintendent in charge. I guess I'm looking for your views. If there was an amendment to confine the reporting responsibilities to those kinds of individuals, would you be comfortable with the legislation?

Mr. Hadwen: The first comment I want to make is that OPSEU is always grateful to be referred to as a professional organization by the member.

On the issue of any amount of narrowing of the legislation, that's preferable. It's problematic legislation for the reasons that have been stated, and if the obligation to report is narrowed, both in terms of who it is that reports and about which things reports are made, that's preferable.

The last point I want to address, that the staff that this union represents are not concerned about violent crime, is not the case. The real issue is, how is it best addressed, and this bill is not the best way to do it.

Mr. Runciman: What is, then?

Mr. Hadwen: What is the best way to do it? There are all kinds of solutions.

Mr. Runciman: Just talk to the police about that.

Mr. Hadwen: Well, that's one of the conversations that's ongoing.

Ms. Rout: When you talked about how we don't care because we don't want to report, that's not what we're talking about. We went into the professions to heal people, to make people better. We didn't come into the field to report them to the police. There should be a process, if you're going to do it.

Mr. Runciman: I don't have any problem with that. I understand your position. My position was that you don't want any reporting. Your legal counsel said that the bill should be defeated. I would respect a position that said, "Look, front-line people—it's the physician and perhaps senior management who should be responsible for that." But to say, "No mandatory reporting; that's not appropriate," I have a problem with that and your obligation and sense of feeling for the community and others who might be involved.

The Chair: I'd like to thank Mr. Hadwen and Ms. Rout for their presentation from the professional organization OPSEU. I'd also just like to inform you that, should you wish to submit any written materials, the deadline for that is still on, meaning Thursday, March 3, at 12 noon. So you still have an opportunity to present any written materials, should you wish to do so.

For the committee members, I'd like to just inform you that you have a schedule for tomorrow in your package.

This committee stands adjourned until 9 a.m. on Thursday, March 3.

The committee adjourned at 1209.

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