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Jeudi 3 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

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON JUSTICE POLICY

COMITÉ PERMANENT DE LA JUSTICE

Thursday 3 March 2005

Jeudi 3 mars 2005

The committee met at 0905 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): Ladies and gentlemen and fellow committee members, good morning. I welcome you to the standing committee on justice policy. These are hearings regarding Bill 110, An Act to require the disclosure of information to police respecting persons being treated for gunshot wounds.

ONTARIO MEDICAL ASSOCIATION

The Chair: I would invite our first presenter of the morning, Dr. Howard Ovens of the Ontario Medical Association. A few housekeeping reminders: We'll be having two presentations back to back now and then recessing from approximately 9:40 till 11:20, when we'll have two further presentations. Dr. Ovens, please come forward and introduce yourself, stating your name clearly for the purposes of Hansard. I remind you, sir, that you and your deputant have 20 minutes in which to make your presentation. Should there be any time left over, that will be divided evenly among the various parties for questions. Please begin.

Dr. Howard Ovens: Good morning. My name is Howard Ovens. I'm an emergency physician and the director of the Schwartz-Reisman Emergency Centre at Mount Sinai Hospital here in Toronto. I'm here today representing the Ontario Medical Association in place of our president, Dr. John Rapin. With me is Barb LeBlanc, director of health policy for the OMA. I'd like to speak today in support of mandatory reporting of gunshot wounds, and I'd like to commend the Minister of Community Safety and Correctional Services for introducing the Mandatory Gunshot Reporting Act, Bill 110.

The OMA section on emergency medicine has been interested in the reporting of gunshot wounds for several years now and was a major catalyst for debate in this area with the publication of our position statement on mandatory reporting in November 2003. The OMA board of directors accepted mandatory reporting of gunshot wounds as official policy in May 2004.

The OMA section on emergency medicine paper, at the back of your handout, is the result of a significant amount of work that included an extensive literature review, the examination of mandatory reporting schemes in other jurisdictions and a survey of Ontario emergency physicians. As physicians, we have concluded from this review and our personal experience that there is a compelling case to be made for mandatory reporting of gunshot wounds in this province.

Before I comment upon Bill 110 in detail, I would like to make it clear that the OMA position deals only with the mandatory reporting of gunshot wounds. We feel that gunshot wounds are inherently different from other violent injuries, owing to their unique lethality, which includes lethality at a distance.

I will remind the committee of two recent tragic incidents, one involving a woman buying a submarine sandwich who was paralyzed by an errant bullet, and the other, a father who was watching TV with his wife and child and was killed by a stray bullet that came through the wall of their home. In both of these cases, the victims were distant from the altercations and uninvolved with them. This is unique to guns. I raise this point to underscore the fact that our support for mandatory reporting of gunshot wounds does not extend to other injuries, and we would not support an expansion of the scope of Bill 110.

Turning to the bill, I will start by noting that the draft law applies to reporting by a facility, and that facilities in this case include hospitals and organizations or institutions that will be defined by regulation. There have been concerns raised that Bill 110 might cause some patients to go to a walk-in clinic or a doctor's office instead of a hospital in order to avoid reporting. Although I expect this would be a very rare occurrence, we recommend that you consider amending the regulation-making authority under Bill 110 to include office-based practices. This will allow the government to move quickly in the event that such an expansion is perceived to be necessary in the future, while at the same time preserving today's focus on our hospitals.

We understand that there is some question about who should make the report to police, and we support the

current form of the legislation. It may not always be practical for the physician to make the phone call, and it is unreasonable to have multiple practitioners—for example, the triage nurse and the attending doctor—making duplicate reports. We believe it is appropriate to place the legislative responsibility for reporting with the facility and to allow each hospital to determine its own reporting practices through hospital policy.

Section 2 of the bill says that the disclosure to police must be made orally and as soon as possible without interfering with the person's treatment or disrupting the activities of the hospital. This is an important clause and we strongly support its intent as written. It is vitally important that reporting is timely, and that will be best accomplished by establishing an easy and efficient process. We do not want cumbersome forms. Not only are they onerous and impractical in the emergency room setting, they would impede timely reporting in cases where, for example, there is a flight risk, a hot trail that should be immediately pursued or a security risk associated with the patient.

0910

Similarly, we have concerns about clause 5(c), the section that gives the government the ability to add new reporting requirements through regulation. Our emergency departments are struggling to meet the demand for life-saving services, and every minute that a physician or nurse spends on government paperwork is a minute that patient care is delayed for not only that patient but everyone in the queue. It is unclear why this regulation-making authority is required. We recommend that it be deleted and that the reporting mechanism be detailed in the body of the legislation.

For my final comment before I close, I would like to discuss something that was an important piece of the OMA section on emergency medicine position paper but is absent from Bill 110. I speak of the need for a database to track gunshot wounds once mandatory reporting is instituted. We believe such a database would provide important information for both the health care and law enforcement sectors. The data obtained from such surveillance would support education, harm-reduction strategies and increased attention to high-risk areas. This is an important element of the reporting strategy in many US jurisdictions and we feel it is also important here in Ontario. Not only will it provide the information I just mentioned, it would be a valuable resource for other provinces that want to review our experience as they seek to deal with their own gun problems.

We think there is a need for a clear statement of political will in this regard. Otherwise, the database will be lost in the myriad of competing political priorities. We recommend that Bill 110 be amended to add the requirement for a surveillance program to complement the mandatory reporting scheme, and that this database be maintained through the public health division of the Ministry of Health and Long-Term Care.

As an emergency physician, I have seen first-hand the physical damage done by guns, but I've also seen the systemic consequences resulting from medical confidentiality rules that are rigid or misunderstood or unevenly applied. Bill 110 provides a clear and unambiguous message to hospitals and to society: All persons who arrive in the hospital with a gunshot wound will be reported to the police. The emergency department environment, by its very nature, requires quick responses, and that kind of response will be greatly facilitated by having a straightforward mandatory reporting scheme.

I urge this committee to support Bill 110.

I'd like to thank you for your attention. I'd be happy to answer committee members' questions in the remaining time.

The Chair: Thank you very much, Dr. Ovens. We have, actually, a generous amount of time left for questions. We'll start with the PC Party. We probably have about four or five minutes for each party.

Mr. Garfield Dunlop (Simcoe North): I wasn't sure what type of concerns you would have when you came in this morning. First of all, I apologize for coming in late, but I appreciate the fact that you intend to support this legislation. It's something that our party, the Progressive Conservative Party, will be supporting as well. We were basically looking for any minor amendments or those types of things that might be added that you think would improve the legislation, more than anything else. Is there anything that you can advise the committee that would be an improvement to the bill?

Dr. Ovens: I'd like to take the opportunity just to emphasize how important I personally, as well as my colleagues in the section on emergency medicine, feel the database is. We feel that in addition to whatever policing benefits may accrue from a real-time investigation of shootings, the public health benefit really depends upon the creation and availability of this information, especially given that we will be the first jurisdiction in Canada to be going this route. Other jurisdictions will be looking to our experience, and it would be very helpful to have some useful and objective data to provide to them. So I would like to emphasize how important I feel that amendment would be.

Mr. Dunlop: But as for your concerns about the actual legislation, you're pleased with the way it's drafted and the amendments. It's just the way it's implemented and the database to follow so we can track it. There's no question that other jurisdictions will be looking at Ontario, as we have looked at other jurisdictions in the United States. I believe 47 or 48 states have supporting legislation as well.

I really don't have anything else, Doctor. I just appreciate your coming this morning.

Dr. Ovens: Thank you for your support.

The Chair: Any further questions, Mr. Dunlop?

Mr. Dunlop: No, that's fine.

The Chair: I turn to the government side. You have 11 minutes, in fact.

Mrs. Liz Sandals (Guelph-Wellington): I'd like to share the time with Mr. Delaney, who has some questions too.

Thank you very much for your input. That's very helpful. I take it that your concern here is driven by the very serious nature of gunshot wounds, the escalation you see in gunshot wounds in emergency rooms, and you're interested in public safety and ultimately reducing the occurrence of that.

Dr. Ovens: Absolutely, but I want to emphasize that this is not strictly a response to urban crime and headlines in the Toronto Star of some very dramatic events recently. We're also concerned with accidental shootings, we're concerned about children who have access to guns, and we're concerned about self-inflicted and domestic shooting occurrences. These are a big issue in rural areas, where guns are even more prevalent than in the city, where we have primarily a gang problem in our headlines. I want to emphasize that it's not just a crime issue; it's a gun safety and public health issue.

Mrs. Sandals: Absolutely. I was quite alarmed by one reference to the instance where you might have a domestic shooting that might not be reported because typically the wife was intimidated and didn't want to report. That would concern me.

I wanted to ask you briefly about a couple of the amendments you've recommended, because I'm not quite sure in my own mind how they would work together. You commented that you like the fact that the facility is to report, that that would give flexibility. But then you've suggested that reporting requirements be laid out more explicitly in the bill and that a database, data collection, be done through the Ministry of Health, which would then seem to put further reporting requirements on hospitals to another body. I'm trying to find in my own mind how the simplicity and flexibility that you like wouldn't be contrary to some of the amendments you've suggested.

Dr. Ovens: First of all, thank you for the opportunity to clarify that. Imagine how emergency departments work. If a patient presents to the front desk with a gunshot wound, the physician may be occupied at that moment. We'd like to be sure that the protection of the act extends to a triage nurse who feels compelled to report for various reasons. There are hospitals in some of the smaller centres where physicians are not on-site in the emergency department 24 hours a day. We'd like to ensure that they don't have to wait for the doctor to come in to make the report, and we want the report to be made by phone.

For the purposes of data collection, there is a certain amount of data already available through health care information collection through the Canadian Institute for Health Information. Then there will be further information collected by the police. I think the challenge is to make sure that the investigative evidence that the police find that normally would not be in a health care document, such as the type of weapon which was used, the circumstance under which the shooting occurred, the location of the shooting rather than the home address of the victim, are things that the police would obtain, and we'd like them to be able to submit that to a database that could be linked to other sources of information, such as the CIHI information.

0920

Mrs. Sandals: So you're not necessarily expecting that the hospital emergency room would be supplying this. You're noting this as a broader concern in terms of information about the whole issue of gunshots.

Dr. Ovens: That's right. Some of our detractors have suggested that this information is already available, but the information in our health care charts or that could be elicited by a physician would not include some of the things I just described, such as the type of gun and ammunition, the location of the shooting etc. These will not be available to a health care document.

Mrs. Sandals: Because you're not an investigator.

Dr. Ovens: Exactly.

Mr. Bob Delaney (Mississauga West): I have one question for you, but just before that, I'd just like to note that I was intrigued by your proposal to set up a database. That's entirely consistent with the mandatory reporting of incidents, in that if you have a body of data, in order for the body of data to be complete, it must therefore capture all of the information. So thank you very much for the suggestion.

I've got a question for you that asks for your comments on some of the things that we've heard from other deputants. Some within the medical profession have raised concerns regarding the reporting of gunshot wounds. Their concerns have focused on three areas: a perception that such reporting is incompatible with patient confidentiality, a perception that such reporting exposes hospital or medical staff to possible intimidation or retaliation, and an expressed view that such reporting is not the job of medical staff. Could you please comment on these three objections from your perspective as a doctor?

Dr. Ovens: Certainly, we consider doctor-patient confidentiality a very high ideal and one which should be contravened only in important circumstances where there's an overriding public interest. We've already defined in our society a number of instances where the public health supersedes that confidentiality rule. These can include such things as unsafe driving, certain infectious diseases, many of them not actually life-threatening, as well as child abuse and a few others. Doctor-patient confidentiality is not an absolute right, and we feel that this issue meets the test of an overriding public interest. I would stress that some of the dire consequences that have been expressed by people who do not support this legislation must be interpreted within the context of a widespread misperception in many people's minds, including some sophisticated people, that this reporting already exists.

Before this issue came to public debate in the fall of 2003, most people, from subliminal effects of American media in Canada, thought that gunshot wounds were reportable, which is something we've detailed in some of our literature. As recently as two weeks ago, my daughter's high school civics teacher strenuously told her

that gunshot wounds and other foul play were reportable in Ontario, despite what my daughter tried to explain to her was going on right now. So if there are bad consequences from reporting, we should be seeing them right now in our society.

Secondly, on the issue of intimidation or retaliation, if we have discretionary reporting, which has been suggested by many people who are against us, then you have the physician bringing judgment to bear and I think more opportunity for intimidation, especially if the police are not involved. If we are merely respecting the law, as we already do—many people are very upset with us when we suggest that they'll lose their driver's licence and their ability to earn their livelihood or that their spouse may find out about their sexually transmitted disease. Emotions can run very high, yet we make those reports and we don't have the police on their way to the emergency department. So I don't see that as a major issue in this case. In fact, if anything, it's an issue in support of reporting.

Finally, in terms of our job, part of our job is obviously maintaining the public safety and protecting the public health. Although it's not our job to investigate crime, it is our job to report. As I said, in these other issues, we have a myriad of obligations to society, whether it's through the maintaining of documents and reporting of information to institutions such as CIHI or to the Ministry of Health, as well as our reporting to the Ministry of Transportation, to children's aid societies, to other authorities such as public health. This is quite consistent with our obligations in these other areas, and it doesn't really change our job description in any meaningful way that I can see.

Mr. Delaney: You said you've seen gunshot wounds up close and personal as a doctor.

Dr. Ovens: Yes.

Mr. Delaney: Have you ever had any trouble, ever been threatened or intimidated?

Dr. Ovens: No, I've not, certainly not related to gunshot wounds. I have had a couple of cases that I described in one of our publications in which the patient asked me not to report. I was very uneasy about that request.

Mr. Delaney: In essence, you're saying that if reporting is mandatory and judgment doesn't have to be exercised, you've essentially made it easier for the physician or the medical staff to comply.

Dr. Ovens: Absolutely.

The Chair: Thank you, Dr. Ovens and Ms. LeBlanc, for your testimony.

POLICE ASSOCIATION OF ONTARIO

The Chair: I would now invite Mr. Miller of the Police Association of Ontario to please come forward. Welcome back. I believe you're a veteran of the pit bull committee hearings as well. I remind you that you have 20 minutes in which to present. Once again, should there be any time left over, we'll divide it evenly amongst the parties. Please state your name clearly for Hansard.

Mr. Bruce Miller: Good morning. My name is Bruce Miller and I'm the chief administrative officer for the Police Association of Ontario. I was also a front-line police officer for over 20 years prior to taking on my current responsibilities.

We appreciate the opportunity to address the committee today and would like to thank all its members for their support and continuing efforts for safe communities.

The Police Association of Ontario is a professional organization representing over 21,000 police and civilian members from 63 police associations across the province. We've included further information on our organization in our brief. We are here today to speak in support of Bill 110 and mandatory reporting of gunshots. It is unfortunate that we, as a society, have reached a point where this type of legislation is needed.

The first observation is that we've become far too litigious. Physicians and health care facilities routinely reported gunshot wounds to police in the past. However, that has changed in some jurisdictions, apparently due to liability concerns, and that change has created a real need for this legislation.

The streets of Ontario have also changed. I remember an incident shortly after I started my career as a police officer with the London Police Service back in 1979. I stopped a car driven by a petty criminal and found a loaded handgun under the front seat. The handgun was nothing compared to the sophisticated weapons our officers deal with today. It was badly rusted and quite dated. However, it was a handgun and everybody wanted to see it when I arrived at the police station. The arrest was even covered by the local media.

Fast-forward to today, and the seizure of yet another handgun evokes little or no interest. Gun violence has become far too commonplace. Senseless shootings dominate newscasts. Monday mornings bring the media's tally of gun violence for the weekend in far too many communities across this province.

Guns are now an accepted part of street culture. Guns and gangs go hand in hand. Both were almost unheard of when I started my career. Guns are also a reality of the illegal drug trade. Firearms are routinely seized by police officers conducting drug search warrants. A drug search warrant with no weapon seized is the exception today. I don't think anybody could have predicted the changes that occurred over the past 26 years since I was sworn in as a police officer.

We need to do more to fight gun violence. We need to make people accountable and to send a clear message that criminal activity associated with firearms will not be tolerated and will result in significant jail sentences, in real prisons and without lax parole eligibility provisions.

We need to do everything we can to fight gun violence. Bill 110 will assist police in combating this growing epidemic. At some point, the right to privacy has to be balanced with the need to protect society.

The PAO appreciates that doctors and nurses have a duty of care that, to some, seems inconsistent with reporting gunshot wounds. While respecting the role of doctors, nurses and hospital staff to care for all those who require medical attention, this shouldn't be done at the expense of community safety. We believe that reporting gunshot wounds does not compromise or impair their ability to provide medical care.

This legislation will enable police officers to investigate all incidents, gather intelligence, help to hold persons accountable, and hopefully prevent future acts of violence. We would ask you to support the legislation.

In closing, we'd like to thank the members of the committee for the opportunity to appear here today. We greatly appreciate your interest in community safety and would be pleased to answer any questions you may have.

The Chair: Thank you, Mr Miller. We have about five minutes per party, and we'll start with the government side.

0930

Mrs. Sandals: I just wanted to pursue the idea that historically people have tended to report voluntarily. If I'm reading between the lines in your presentation, I'm guessing there are a lot of jurisdictions in which that still happens. Is that correct?

Mr. Miller: Our information is that the vast majority of jurisdictions in Ontario do report gunshots. This issue seems to have grown out of the Toronto area.

Mrs. Sandals: So it would be fair to say that if there were problems from the point of view of hospitals in terms of threats—and we've heard from hospital workers who are concerned about liability, all these issues—in fact there is a fair body of experience in Ontario with reporting gunshot wounds already, because in significant chunks of the province that's the practice anyway.

Mr. Miller: I can't remember any threats related to reporting. I think a lot of the criminal element thought it would be reported in any event. I can tell you that a lot of times—and I've worked closely with emergency staff over the years and really was privileged to see the wonderful work they do in emergency rooms with these cases. But there's also a safety aspect for the hospitals involved, for the staff, for the people in the waiting rooms, because certainly we've seen incidents where retaliation has been attempted or has taken place right in emergency rooms. I think that's why we see the armed guards in a lot of American cities now. There have been shootings. I know certainly with organized crime members and things of that nature, and sometimes domestic violence, there is a big concern that somebody is going to try and repeat the same incident. It puts emergency staff at risk and it puts the public waiting in those rooms at risk as well. I think that was a good reason why the reporting was done.

Mrs. Sandals: So, from your experience, there may sometimes be problems with people who want to finish the job, if I can put it that way.

Mr. Miller: The concern is always there in many cases.

Mrs. Sandals: And making sure the police are always aware would in fact provide a greater level of security for hospital staff because it's an automatic that they will report, and then the police will be following up, so they don't need to worry so much about security issues that that particular patient may attract.

Mr. Miller: Certainly there were a lot of security concerns raised by hospital staff with certain patients, and rightfully so.

Mrs. Sandals: Thank you very much. It's helpful to get that perspective.

The Chair: Any other questions from the government side? Mr. Brown or Mr. Delaney?

Mr. Michael A. Brown (Algoma-Manitoulin): First of all, I'd like to say how much we appreciate your being here today to get your point of view.

I've been trying in my own head to understand the scope of this problem. Just for the help of the committee, maybe you could outline the increase in gunshot incidents in the province, and particularly here in Toronto. You allude to that. I'm sure your organization keeps very careful statistics on that. It would be helpful, as we make our judgments on this, that we have some sense of the statistics that are involved.

Mr. Miller: We tried to get some statistics, but statistics are so misleading when we're dealing with gun crimes. I mean, we have issues with the gun registry which can throw off the statistics. In terms of gun crimes, if we're talking actual gunshots and incidents, I did some checking last week before appearing at the committee and just couldn't find any hard statistics that were really relevant, because the way Statistics Canada tracks so many crimes, they associate it to weapons, which can be a rather misleading statistic. I think the best judge is just what we see in today's paper. Certainly from the front-line people, we never saw these incidents years ago related to gun crimes. It's an epidemic out there, but we couldn't get any hard-and-fast statistics or find a database that helped us.

Mr. Brown: That in itself worries me, that we don't keep track in some way. We just had a physician here who said that one of the things they needed to do in reporting was to keep some statistics so there was some good, hard information.

Mr. Miller: One of the things too is that gun crimes are a relatively new phenomenon that we've just seen in the last 10 years where it has exploded. Statistics Canada never tracked those; they were tracked in a sort of grab-bag section. That's why we don't have the statistics available.

The Chair: An efficient question, Mr Delaney?

Mr. Delaney: I always ask efficient questions, Mr Chair.

First of all, I want to thank you for coming in, because you've brought a very interesting perspective to the debate. It's an operational perspective, because you've driven the route in the car. From your experience as a police officer, when a report of a gunshot has taken place, what typically happens? In other words, from our

perspective in dealing with the bill, what activities could we expect police officers to take once a report has come in? That's the first part. The second part is that you've talked about StatsCan and the dearth of information. From your extemporaneous design, what type of information would be appropriate for you to capture in a gunshot wound incident?

Mr. Miller: To the second question first, we'd have to look at that whole question of a database, because some of the items that we would want to see tracked, such as age and other things like weapons used, would not be the same areas that the medical community would want tracked. We might run into privacy problems there as well. If there was a move to establish a database—and we realize that money is tight and we always have to look at things in terms of priorities—I think we need to sit down and decide what would be useful.

In regard to the other question, if a gunshot is reported by a hospital—we'll do the hospital—the first concern would be that patient at the hospital, to make sure there are no security problems there. Then it would be to start the investigation and try to secure the scene where the shooting occurred.

Certainly timely reporting is very important. We have no concerns with the reporting mechanism now. We're sure that hospitals can create policies. I've been in the emergency rooms. I know how busy the doctors and the triage nurses are. Every hospital is different, but everything is charted and I'm sure there is a mechanism for local hospitals to report it right away.

The Chair: We now turn to the PC side.

Mr. Dunlop: Thanks very much, Bruce, Mr. Miller, for being here today and for your presentation. A quick comment on the data: We keep asking our professional people in this province for more data. If you talk to doctors and nurses now, to schoolteachers, they'll tell you that so much of their time is already spent providing paperwork to authorities as part of their job. It's nice to keep asking for more data on all these specific areas, but it does take away from their professional work.

On Bill 110, we're specifically referring to gunshot wounds at this time. My question to you is, what about other kinds of wounds that people have, like a knife wound, a stab, or where somebody has obviously been beaten badly by some kind of weapon? Where do you think we should go from this point? Is that not probably the next step with legislation like this?

Mr. Miller: I'm only speaking from a policing perspective and from a community safety perspective, but obviously there would be some benefits to mandatory reporting of knife wounds and things like that. It's a difficult issue, because you run into accidental wounds and things of that nature. If a person is incapacitated with head injuries, something of that nature, there's probably a need to look at mandatory reporting just because, in some cases, a person is unable to report that injury himself or herself.

Mr. Dunlop: I guess that's my concern. Will that be another piece of legislation down the road, or should we work on that now? That's why I was asking the Ontario Medical Association if there should be amendments to the legislation that would add some of these other things. I'm thinking of a knife wound. If you're going to report a gunshot wound, why wouldn't you report a knife wound? Or is that another piece of legislation for another day? That's my question to you and that's my question to the government members. Why wouldn't we take a look at that?

Mr. Miller: The one problem with knife wounds is that you always have to ensure that they weren't accidental.

Mr. Dunlop: Yes, but the same thing could happen with a gunshot wound, couldn't it? You could blow your kneecap off or something.

Mr. Miller: Fair enough, but there are so many knife wounds in an emergency room in terms of cuts and things like that that have been stitched up. In a best-case world from a policing perspective, we would like to see knife wounds reported. We would like to see very serious assaults reported, especially if a person is incapacitated. I can remember a case where somebody was unconscious for two days and it wasn't until they came to that it was reported. But as I said before, most of these are reported across the province. It's just unfortunate that times change and this sort of legislation is needed.

Just one more quick thing on knives: It is certainly be something we'd have to sit down and discuss and look at some parameters for, but there would be value in it.

Mr. Dunlop: I appreciate the opportunity.

Mr. Mario G. Racco (Thornhill): Do we still have some time?

The Chair: Sure. Please go ahead.

Mr. Racco: I am interested in hearing more about what Mr. Dunlop asked. I'm one of those who believe that any criminal activity must be reported. I really don't sympathize with people who look for excuses not to do so, because if there is a problem, it should be reported and addressed. I think that's basically what you're saying.

When you make reference to a knife and that the cut could be done by the same person, it's not a criminal act. I know there are no statistics. What percentage of people go to the hospital with a cut that maybe is an error instead of it being a criminal act? Any idea?

Mr Miller: For self-inflicted knife wounds, the police are usually involved, because there's a concern for the patient and the security risk. It would be wonderful if we could just make legislation where common sense prevails, because—

Laughter.

Mr. Miller: It's a real challenge, I know. So many times the wounds we see associated with knife attacks are so self-evident, as opposed to the cut that needs a couple of stitches because someone's knife slipped in the kitchen or while cleaning fish or whatever. But it's something we'd be more than willing to explore, and there would be merit in it.

Mr. Racco: I think we should look at those realities. An unwanted cut is a criminal activity, and the police must know because that's only the first potential step to something major that can happen. Therefore, I hope that at least your organization will potentially look at suggesting that we go a little further in this legislation or in future legislation.

The Chair: Thank you, Mr Miller, from the Police Association of Ontario. Committee members, I advise you that we are recessed till 11:20.

The committee recessed from 0944 to 1120.

The Chair: I'd like to welcome the committee members back, as well as the individuals who will be bringing deputations to the standing committee on justice policy on Bill 110, An Act to require the disclosure of information to police respecting persons being treated for gunshot wounds.

ONTARIO HOSPITAL ASSOCIATION

The Chair: I'd now like to invite the first presenters, from the Ontario Hospital Association. Please introduce yourselves for the purposes of Hansard. I remind you that you have approximately 20 minutes in which to offer your remarks. If there's any time left for questions, we will divide it evenly between the parties, now that they are in fact here. Please commence.

Ms. Hilary Short: Thank you for the opportunity to be here. I am Hilary Short. I am president and CEO of the Ontario Hospital Association. With me are Mary Gavel, director of risk management and patient relations at Rouge Valley Health System, and Elizabeth Carlton, senior adviser, legislation and policy at the OHA. We are pleased to be able to appear before you this morning on Bill 110, the Mandatory Gunshot Reporting Act.

Given the importance of this issue for hospitals, the OHA has consulted broadly, seeking input from its advisory committees and conducting a survey of members. Informed by this input, we welcome the opportunity to provide our comments and recommendations respecting the bill.

As you can appreciate, the issue of reporting to the police has long been a challenging one for hospitals, as it strikes at the heart of a fundamental tenet of care, that being the protection of patient confidentiality. Hospitals face a dilemma in wanting to ensure that the hospital is a place of refuge and care for patients, while at the same time doing what is necessary to enhance public safety. As a result, there are, understandably, differing and strongly held views on the subject. In offering our thoughts on the legislation, we would like to acknowledge these divergent views and the conviction with which they are held.

While I cannot say that all hospitals universally support mandatory reporting, it does appear that there is general agreement that mandatory reporting would serve to clarify responsibilities and avoid the need for individual health care providers to decide when to report and/or collaborate in a police investigation.

In accordance with the common law duty to warn, hospitals have traditionally reported gunshot wounds when there is a risk of serious harm to an individual. Indeed, this practice was codified in the new privacy legislation, the Personal Health Information Protection Act, 2004, passed last year. This legislation permits disclosure if it "is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons." As you can well imagine, making this determination of risk is not easy.

As a result, many hospitals appreciate the fact that Bill 110 would, at least for cases of gunshot wounds, relieve health care providers of the responsibility of making a determination as to whether someone was at risk and whether a report should be made. However, it must be acknowledged that a number of hospitals do not believe that the need for mandatory reporting outweighs the need to safeguard patient confidentiality. It must be said that those with a long history of serving the mental health community have expressed great reservation about the lack of any exemption for self-inflicted wounds, as it is felt that police involvement may further stigmatize those injured as a result of a suicide attempt. We expect that they will be making submissions on this issue and would encourage the committee to consider these carefully.

Those hospitals which are supportive of mandatory reporting have significant concerns with the proposed framework for reporting set out in Bill 110, believing that the bill could be improved in this regard. I will now ask Mary Gavel to speak to these issues from the front lines.

Ms. Mary Gavel: Thank you, Hilary. While we have noted a number of suggested amendments in our written submission, I would like to take this time to focus on a couple of important areas in which the legislation could be strengthened.

The first issue relates to the somewhat narrow application of the act. By virtue of the definition of "facility" found in section 1, the legislation applies to hospitals under the Public Hospitals Act and "an organization or institution that provides health care services and belongs to a prescribed class." Although the bill clearly states that regulations may be made prescribing these other organizations or institutions, we would suggest that not all should be determined by way of regulation. We suggest that it would make sense to include physician offices, after-hours clinics and other community health care centres within the ambit of the legislation and would encourage you to engage their representatives in further discussion on this issue.

The concern is that, in the event that regulations are not enacted, individuals may elect to seek treatment in facilities other than hospitals in order to evade police detection. Further, with recent health care transformation initiatives launched by this government, concerted efforts are being made to move care into communities and, where possible, away from institutions such as hospitals. In such a climate, we believe it is only logical to ensure that facilities offering primary care be covered by the legislation. Similarly, given that the purpose of the

legislation is to enhance public safety, there is some question as to why only gunshot wounds are reportable and not all injuries relating to violence, with stab wounds being an obvious example.

Another area that we would urge the committee to examine carefully is how gunshot wounds are reported. We think that the legislation needs to be clear about precisely who should be responsible for reporting. Bill 110 simply states that the "facility" has to report, which leaves open to interpretation just which individual within the facility will be making the report. While this is certainly a matter that could be determined by each hospital, this would require the development of facility-level policies and guidelines. Further, we would suggest that identifying the individual responsible for reporting would also be consistent with similar mandatory reporting provisions, such as in the case of child abuse. In the interests of facilitating a more even uptake and application of the law, we would therefore recommend that the individual responsible for reporting be clearly identified in the legislation.

In polling its members, OHA has found that hospitals believe the most appropriate person would be the attending physician, given their role in diagnosing the patient. However, recognizing that this may not be practical in every instance given workload and patient volumes, we acknowledge that from time to time this responsibility might need to be delegated to other health care professionals.

We also note that the legislation is silent on the question of retention and/or disclosure of the police record. Given the potential impact on an individual's future employment or other activities, we would urge the committee to give serious consideration to this matter and provide for safeguards in this regard.

Finally, because of the controversial nature of this bill and the potential for unintended consequences, we suggest that it would be advisable to mandate a review of the legislation after a period of three years.

These are critical issues that must be addressed by this committee before the bill is referred back to the House. The legislation will have an enormous impact on hospitals and we therefore believe it is vitally important to get it right.

Once again, thank you for the opportunity to appear before you. We would welcome any questions you may have.

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The Chair: Thank you very much for your deputation. We will have quite a bit of time for questions. We'll start with the NDP caucus.

Mr. Peter Kormos (Niagara Centre): Thank you kindly. Mr. Runciman is going to read this; I'm sure he'll be comforted, because you join him in some of the proposals he made yesterday.

I've been listening to and reading not only your submission but also others. I'm interested in the matter of identifying the person who's going to be doing the reporting. I learn, in addition to what you say, that physicians, for instance, already have—I want clarification, if you can; maybe somebody else will have to provide it—a duty or an opportunity to report, if they believe that that person poses a danger. I don't know whether it's a duty or simply that they are released from their requirement of confidentiality if they believe so. Similarly, the Ontario College of Nurses, which has not supported Bill 110, talks about nurses having, again, this inherent ability to report when they believe that there is a risk being posed.

What I'm interested in is, which of the hospital staff people are going to submit themselves as potential witnesses, by virtue of doing the reporting, and spend three and four days sitting in a crummy hall room down at Mimico—have you ever been to the Mimico provincial court? Probably not.

Ms. Short: No.

Mr. Kormos: It's a horrid place.

Mr. Dunlop: Peter's been there.

Mr. Kormos: I've spent a lot of time there; I admit that readily.

Which doctor is going to want to sit there in the midst of, let's say, a biker gang trial or a drug dealer trial, being eyeballed by biker gang members, knowing that they're a witness against the interests of the accused? Which health professional should have to be submitted to that: the doctor, or a nurse who is part of a profession that's been under attack and short-staffed, and who is hard-pressed to keep up with his or her responsibilities as they are now?

Ms. Short: I'll start. It's under common law that if they believe that someone is endangered by the result of something, they are required to report that. That was codified in the new privacy legislation.

Mr. Kormos: You made reference to that.

Ms. Short: I'm not sure of the legal processes that happen after that, but we're saying that in terms of the hospital, you really have to diagnose or know that someone has been injured by a gunshot wound. Therefore, we think that within the hospital, the responsibility for reporting should primarily be the attending physician's. But under some circumstances they may need to delegate that, as with other medical acts, to someone else.

Mr. Kormos: So in your view, he or she is the one who gets to cool their heels for three and four days at a time in provincial court during a preliminary hearing?

Ms. Short: Yes. I guess this is where law and medicine come together. Under the health professions legislation, it's only physicians who can diagnose, and you have to diagnose or be told that this is the result of an accident. Mary can say that in practical terms, obviously sometimes you diagnose it, or the patient will tell the physician under certain circumstances that it's a gunshot wound.

Mr. Kormos: The other big area of concern is attempted suicide. Obviously, successful suicides are irrelevant in this context. Attempted suicide is no longer a crime. I'm concerned, and so are some of the participants, about the fact that a person who has done an

attempted suicide—and I've seen the stats for gunshot admissions into emergency wards: accidental discharge, self-inflicted, and then, quite frankly, the criminal part of it is not the greatest part. So what about the person who has attempted suicide? It seems to me that the last thing they need is police intervention.

Ms. Gavel: And our member hospitals did raise that concern as well.

Mr. Kormos: Should there be discretion, then, on the part of the reporting person to exclude reporting an attempted suicide, or somebody who has been cleaning their rifle—it happens—and who shoots themselves literally in the foot?

Ms. Short: This is one of the difficulties with the legislation. This is where the differences of opinion come in. Many health care professionals feel that the hospital is a place where your prime concern is caring for the individual who comes in, regardless of what reason they are brought in, and that confidentiality supersedes everything else. There are other aspects to this bill, as we say, that relate to public safety. This is the grey area. Within our own membership, there are considerable differences of opinion about this. On balance, if you live in Toronto and you see the issues related to guns and gangs and so on, hospitals want to play their role in that.

But there are some very difficult issues. We know that the mental health community is very concerned about this piece of it, not further stigmatizing people with mental illness who may be trying to take their own lives. About accidents, again there's a bit of a grey area.

The Chair: Thank you very much to the NDP caucus. I will now move to the government side.

Mr. Racco: I have a simple question. You make the statement on page 4 that gunshots should be reported. Who, in your opinion, should do the reporting? Could you give us some recommendations on that?

Ms. Gavel: I think the member hospitals felt that it needed to be the attending physician who would make that diagnosis. When the person presents to the emergency department in a hospital, they don't always present stating, "I've been shot by a gun." They present with a number of other complaints. As Hilary said, the physician is the only one who can make a diagnosis that it was a gunshot wound. The member hospitals felt it was appropriate to delegate to another health care professional to actually make that phone call, but the physician clearly needs to be the one making the determination that it's a gunshot wound.

Ms. Short: The thing you have to remember too is that it may not be obvious that someone's been shot. You may be grazed or you may be severely injured with a bullet. But it does require diagnosis or it does require the patient to tell the health care professional.

Ms. Gavel: And they don't usually present, unless it's very obvious, stating, "I've been shot by a gun."

Mrs. Sandals: I'd like to follow up on this whole issue of who reports, because we've had quite conflicting evidence. I don't think anybody would dispute that it's going to be the physician who makes the diagnosis. I'm wondering why, when you're managing a busy emergency room, you would be concerned that the physician is actually the person to make the call. What we're hearing from the emergency room physicians is that they are quite comfortable with each local hospital being able to develop its own protocol for how that would work. The emergency room physicians are saying that in some cases, once they've made the diagnosis, someone else could be delegated to make the call, whereas if you put in the legislation explicitly that the physician is required to make the call, then you're taking the physician away not from the responsibility of making the diagnosis but from treating that patient or other patients.

Ms. Short: That's why we're suggesting that hospitals can develop their own policies for delegation, because it's a common procedure in hospitals to delegate something to another health care professional. In some cases, they delegate medical acts. We're saying that the physician is the one responsible for diagnosis; hospitals can then develop their own policies and procedures for delegation. That's what we're saying.

Mrs. Sandals: But that's my understanding of what the proposed legislation's wording allows.

Ms. Elizabeth Carlton: The legislation, as we read it, simply states that the facility must report. It's not identifying a particular professional within that facility who has that responsibility. In terms of consistent uptake across the board, it would make sense to say that the attending physician should report and, where necessary, delegate that act.

Mrs. Sandals: If we can go to the Child and Family Services Act, an act with which I have a fair degree of familiarity, there are a number of primary caregivers and people who would interact with children. It cites teachers and so on. My understanding of that act is that because teachers are named, physicians are named and so forth, the legal advice that school boards have received is that the the teacher does not have the legal authority to delegate because they are specifically named. To draw a parallel, it would seem to me that what you're suggesting would get you into the situation where if the physician is specifically named, you might in fact have trouble with delegation.

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Ms. Carlton: You could also add in that provision words to the effect that "and where necessary, his or her delegate," so it's clearly expressed in the legislation that this can be delegated, which I don't think is the case in the Child and Family Services Act.

Ms. Gavel: Maybe something else in terms of the language is to have the physician making the determination, and then the actual call to report could be delegated once the physician has diagnosed or made the determination that it's a gunshot wound.

Mrs. Sandals: If I can summarize, I think I'm hearing that the physician needs to diagnose and then there can be some flexibility around who makes the call.

Ms. Short: And just to emphasize that within a hospital setting, delegation is an accepted and common

practice for lots of things. Hospitals can delegate medical acts to nurses or other health care professionals provided it's spelled out and they have policies for how it's done. Unlike, say, in a school, delegation is a very common activity in hospitals.

The Chair: I now move to the PC caucus.

Mr. Dunlop: First of all, thank you very much for coming. I know it's a bill that we have a lot of different opinions about. In terms of the legislation, I was very interested that you mentioned that just gunshot wounds are reportable under the bill. When Bob Runciman introduced a resolution in December 2003, it called for knife injuries as well under that resolution, and I would have hoped this bill would have included that. How would you feel about amendments being made to the bill that would include other types of wounds as well? Maybe you haven't even had a chance to discuss that yet.

Ms. Short: We've given a lot of thought to it, and I'll let my colleagues talk.

Ms. Carlton: When we surveyed members last summer, there was some support for including stab wounds. That issue has also been a challenging one for hospitals for a long time. Initially, when there was a movement afoot to draft something, there was support for including stab wounds as well. I can't say there is universal endorsement of that, but I think it is an important issue for the committee to consider, going forward.

Mr. Dunlop: Why I feel that our caucus would probably support that is that it's my understanding that, by and large, there are far more knife wounds or knife injuries than there are gunshot wounds, and I thought it would be a good opportunity to clean the legislation up once and for all. Maybe it wouldn't clean it up once and for all, but it might make it a little more all-encompassing.

Ms. Gavel: I think that was raised, because if you're looking at it from a public safety perspective, absolutely. There are gunshot wounds, but stab wounds are probably a lot more prevalent.

Ms. Short: I'll just add, though, that this is where the difficulty comes in. You've got gunshot wounds, you've got stab wounds, and there are many other kinds of criminal activity which result in violence and people being taken to hospital, and it's difficult to be all-encompassing. This is some of the concern of health care professionals: How far do you go in asking health care professionals to report on the reasons people are being brought to hospital and making judgments about elder abuse or violence against women and so on? I guess that's the issue. If you do gunshot and knife wounds, how much further?

Mr. Dunlop: Well, maybe the next thing is a bow and arrow or something like that.

Ms. Gavel: Also, with the stab wounds as well, what about the accidental or the self-inflicted?

Mr. Dunlop: Absolutely. A guy cuts his hand skinning a fish or something like that.

The Chair: I'd like to thank Ms. Short, Ms. Gavel and Ms. Carlton from the Ontario Hospital Association for their deputation.

REGISTERED NURSES ASSOCIATION OF ONTARIO

The Chair: I would now invite Ms. Irmajean Bajnok of the RNAO to come forward, if she is here. If you have any written materials, please feel free to offer them to the clerk. We'll have them distributed for you. I remind you that you have approximately 20 minutes in which to offer your remarks and the time remaining will be divided evenly among the various parties. Please identify yourself by name for Hansard recording purposes and please commence.

Ms. Irmajean Bajnok: I'm Irmajean Bajnok and I am the acting executive director of the Registered Nurses Association of Ontario. I believe you are receiving a copy of our submission. I want to say how pleased we are to have the opportunity to address this group. I want to also introduce Sheila Block, who is with me today. She is the director of nursing and health policy at RNAO.

RNAO, as many of you know, is the professional association for registered nurses in the province. They practise in all roles and sectors across the province. Our mandate is to advocate for healthy public policy and for the role of registered nurses in enhancing the health of Ontario residents. We welcome this opportunity to present our views on Bill 110 to the standing committee on justice policy.

We understand that the government has introduced Bill 110 out of a concern for public safety, and that is to be applauded. However, we cannot support this legislation, which we feel would place an additional obligation on health care professionals to report to police when a person is treated for a gunshot wound.

Let's be clear: Most of the time, it will be a registered nurse who will be obligated to report. RNAO believes this obligation will have a negative impact on the confidentiality aspect of the therapeutic relationship between registered nurses and patients. The notion of confidentiality is essential to nurses gaining and maintaining the trust of the patient, and a critical factor in successful care and treatment. If registered nurses must act as an extension of law enforcement, it will have a chilling effect not only on patients with gunshot wounds but, we believe, also on other vulnerable clients.

We are concerned that mandatory reporting of gunshot wounds could deter people with such injuries from seeking treatment. This could further jeopardize the safety of such individuals as abused women, families and their children, and teens. This could also spill over to other patients who may be less inclined to seek the care they need or provide information crucial to their recovery if they know this will be reported.

We believe public safety concerns in regard to gunshot wounds are currently very well addressed by the standards of nursing practice set out by the College of

Nurses of Ontario, the regulatory body for all nurses in this province. These standards already provide for voluntary, rather than mandatory, reporting. They allow registered nurses to use their professional judgment to decide when it is in the public interest to report gunshot wound victims and in fact many other types of wounds and injuries. If safety concerns outweigh those related to patient confidentiality, nurses can and indeed are obligated to report any treatment or health care condition, including gunshot wounds.

Furthermore, we believe that mandatory reporting will not be an effective policy to increase firearm safety. Evidence indicates that almost two thirds of gunshot wounds that require hospital admission were either accidental or self-inflicted. Again, as many of you know, 78% of deaths from gunshot wounds were related to suicidal situations. As a result, RNAO firmly believes that a focus on prevention through firearm safety education and mental health services would be a more effective focus for policy in this regard. In rural areas where hunting is more widespread, mandatory reporting could divert scarce health care resources to reporting accidental injuries and away from more productive use of time on the part of both registered nurses and police officers.

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Finally, we believe that the most effective policies to reduce violent crimes are those associated with the social determinants of health: those that reduce discrimination and inequality and those that address nutrition, affordable housing and child care.

Confidentiality is a key principle of health care and registered nurse practice. RNAO believes that current standards of practice adequately address the needed trade-offs between public safety and confidentiality. Furthermore, we do not believe that mandatory reporting is the most effective policy tool to reduce firearm-related injuries. We therefore strongly urge this committee to recommend withdrawal and reconsideration of Bill 110.

In conclusion, this position is fully supported by all of the province's major nursing organizations: the College of Nurses of Ontario, the Ontario Nurses' Association, and the Registered Nurses Association of Ontario.

Thank you once again for the opportunity to make this presentation. We are happy to answer questions.

The Chair: Thank you very much for your deputation. We'll start with the PC caucus.

Mr. Dunlop: I understand that you're against the legislation. I'm curious about whether you've had an opportunity to look at your colleagues south of the border, where I believe 45 or 46 of the states have legislation similar to what the government is trying to introduce right now. I wonder if you've had any feedback from those areas.

Ms. Bajnok: In fact, one of the things we did look at was the evidence in terms of the result of such reporting on changes in crime behaviour. We certainly could not find that kind of information. That's what we were looking at—the impact of this legislation on violence—because we feel there are the concerns about confidentiality but also about public policy and use of resources.

Mr. Dunlop: That's the only question I had, Mr. Chair.

The Chair: Mr. Kormos.

Mr. Kormos: Thank you, both of you. This is fascinating. I underlined the part where you talked about the discretionary power of a nurse to report when, in his or her judgment, it's in the public interest to do so. We're similarly told that doctors have that discretion available to them. I read the Police Association of Ontario's submission this morning. They of course are advocating for this, but they didn't make reference, at least in their written submission, to a single instance where they, for instance, missed out on an illegal shooting. Maybe the solution is simply educating everybody about—because nurses are well trained about their discretionary ability to report, aren't they?

Ms. Bajnok: Nurses are certainly aware of the standards of practice from the College of Nurses under which they are all obligated to practise. I would just suggest that it is an obligation, an ethical obligation, to do that reporting.

Mr. Kormos: I'm concerned about the person who attempts suicide. Police do what police do, and I understand that. They know they're not social workers, and they abhor being thrust into situations where, for instance, their role is not the useful role. In the case of an attempted suicide, it seems to me that the last thing we should have an interest in is getting the police involved. That patient warrants other things. And where it's clearly an accident—you heard me refer to the proverbial circumstance where you shoot yourself in the foot while you're cleaning your firearm.

Let me put it this way. Some people are going to try to concoct the image of a multiple murderer getting shot in the course of a mass murder—I don't want to stigmatize, but Tony Soprano, you know what I mean?—showing up at a hospital with a gunshot wound, and somehow nurses and doctors are all going to be oblivious to the fact that there was a mass murder just down the street and that this guy happens to show up in the hospital within 30 minutes of the report of people being shot. Somebody's going to try to create the impression that nurses or doctors wouldn't report that to the police. Is that proposition silly?

Ms. Bajnok: Well, it's a hypothetical situation. I'd go back to the key aspect of the standards, which clearly states that if nurses feel that anyone who presents themselves to the health care system is at risk of endangering the public, they are obligated to report that. There is a process where they discuss that with the team and report that. I would have to say that my view is that nurses understand the standards of practice and do follow them.

Mr. Kormos: It makes me wonder whether this bill isn't just a cheap appeal to the overall and overriding fear of guns and proliferation of guns in crime, when in fact all of the processes we need to address this seem to be in place already. I have regard for what you say. Is this just

the Liberals trying to out-law-and-order the Tories? Monte Kwinter and Bob Runciman will arm-wrestle over who can be more law-and-order on this issue. They will mud-fight, if need be, to see who'll be more law-and-order. Mark my words. That'll be a show to see.

Ms. Bajnok: We also feel, though, that if you want to look at where you put your efforts around public policy in relation to violence, there are many other places.

Mr. Kormos: You made submissions in that respect. I appreciate that.

The Chair: Thank you, Mr. Kormos. I'm sure the committee looks forward to that event.

I turn to the government caucus. You have approximately five minutes.

Mr. Delaney: Personally, I look forward to seeing Bob Runciman mud-fight.

You state that the proposed mandatory reporting of gunshot wounds will affect the "confidentiality aspect of the therapeutic relationship," to use your own words. Yet the Canadian Medical Association's code of ethics requires physicians to "respect the patient's right to confidentiality except when this right conflicts with your responsibility to the law, or when maintenance of confidentiality would result in a significant risk of substantial harm to others or the patient." The Ontario Medical Association endorses the mandatory reporting aspect of the bill. In the United States, similar statutes exist in Vermont, New York, Minnesota, Florida and Texas. Could you please explain the discrepancy?

Ms. Bajnok: Our code of ethics and our standards of practice suggest the very same thing, that when concern for public safety overrides the concern for privacy, one is obligated to report. We're saying that anything that means a blanket reporting truly interferes with that, and we feel it will have negative consequences for those individuals who do not put the public safety at risk. That's when you're looking at endangering the nurse-patient relationship and in fact perhaps having the effect that individuals will not come for care and treatment. Do you understand what I'm saying is the difference?

Mr. Delaney: Well, I'm having a hard time visualizing a concrete example of it.

Ms. Bajnok: It's in a situation where you're attempting to commit suicide or you've been cleaning your gun and you have a gunshot wound. Because of the legislation, that information has to be reported. We are saying that that interferes with the confidentiality; there is no public safety risk. It's in those cases where the risk to public safety overrides the risk for confidentiality that the nurse is obligated to report; otherwise, no.

Mrs. Sandals: In your brief and in your testimony, you're talking about the fear that if this legislation is put in place, it will interfere with the patient-nurse relationship, that it will lead to instances of people failing to seek treatment. However, we're told by the police association that the reporting relationship required in this act is the practice already in most of the province. Given that this is already the practice, although not the legal requirement, in most of the province, do you already have any instances where reporting has interfered with the patient-nurse relationship or where there are actual incidents of failure to seek treatment? We are told that in most of the province, this is already the practice.

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Ms. Bajnok: I'm not aware that that is already the practice. My understanding, certainly from our membership, is that nurses do look at the reporting related to a threat to public safety.

Mrs. Sandals: But in that we're in agreement that there is already, in most of Ontario, a lot of reporting going on, are there any actual instances where the reporting has led to harm to a nurse, where there have been actual instances of interference with the treatment relationship? This all seems to be presented in terms of, "We're afraid that this will happen."

Ms. Sheila Block: If I can clarify, when you're saying what is happening already, it's already happening under the regulatory regime of the college standards. Those standards would just have RNs reporting when they saw a perception of danger to public safety. The situation where RNs don't think there is that danger to public safety, and therefore they are not required to report, hasn't come up yet.

I also think it's very different when you have legislation, and the media associated with that, that says, "All gunshot wounds need to be reported." To try to compare the situation currently, under a regime that we think is adequate, isn't necessarily the best kind of comparison to what could occur in the future.

Mrs. Sandals: Do I have a few minutes, or are we out of time?

The Chair: Mr. Racco also asked for a question.

Mrs. Sandals: I wanted to follow up on the issue around professional judgment, which you've just alluded to. We have heard from a number of presenters about that professional judgment: Is this self-inflicted? Does this present a danger to public safety? When should you report? When shouldn't you report? A number of the presenters have said to us that they appreciate having it clarified: "This is exactly what must happen."

Ms. Bajnok: One of the things to keep in mind is that the way the college standards are presented is that there is first that acknowledgement: "This looks like something that should reported. This looks like a safety issue." Then there is always that opportunity to dialogue with the health care team, so you're getting a team perspective and point of view. So I'm not certain that it's as major an issue: You have a presenting gunshot wound and you make the decision. It's the same as with what we were talking about before, other kinds of injury inflicted through violence. You still have to make that judgment. We might have the legislation about gunshot wounds; the next thing, you have someone coming in with a stab wound or a blunt object being thrust at them. So there still is that professional judgment situation. What we look to is that opportunity to dialogue with colleagues if there is uncertainty.

The Chair: Mr. Racco, last question; quickly, please.

Mr. Racco: It's clear in the OHA presentation that they believe it's better that all gunshots are reported. If Bill 110 passes, it makes it the law that health care professionals must report. My question is, wouldn't that be better than leaving flexibility to health care professionals to make the decision to report or not to report? Wouldn't it make your job easier if you must report?

Ms. Bajnok: I don't believe it would. First of all, you're only talking about one type of injury that might inflict problems for the rest of the public. Second, you're talking about introducing some challenges to the nurse-patient relationship, which we think could make it more difficult for nurses to work closely with patients and carry out the appropriate care and treatment. Third, we feel it would add to the many roles and functions of registered nurses currently in busy health care organizations. The full consensus is that it wouldn't make the role easier.

The Chair: Thank you very much, Ms. Bajnok and Ms. Block, of the RNAO.

Mr. Kormos: Chair, before we adjourn, may I make a request to legislative research, please?

The Chair: Please.

Mr. Kormos: I appreciate that this is not as straightforward as I wish it was, but surely there has been some debate around the compulsory reporting of spousal abuse in terms of a woman's right to control that facet of her life. I'm wondering if you could come across point-counterpoint in terms of that debate, with the obvious relevance to what is being discussed now and the concern about whether that endangers women who might be victims of gunshot wounds from partners.

The Chair: Thank you, Mr. Kormos. Research has noted your request.

Housekeeping items for the committee: The deadline for written submissions expires now. The deadline for submitting amendments will be Monday, March 7 at 4 p.m.

This committee stands adjourned until Wednesday morning, March 9, for clause-by-clause consideration; time notification to follow.

The committee adjourned at 1206.

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