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M-17

Standing Committee on the Legislative Assembly

Protecting Patients Act, 2017

2nd Session
41st Parliament

Wednesday 3 May 2017

Chair: Monte McNaughton
Clerk: William Short

Journal des débats (Hansard)

M-17

Comité permanent de l'Assemblée législative

Loi de 2017 sur la protection des patients

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Mercredi 3 mai 2017

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CONTENTS

Wednesday 3 May 2017

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON THE LEGISLATIVE ASSEMBLY

COMITÉ PERMANENT DE L'ASSEMBLÉE LÉGISLATIVE

Wednesday 3 May 2017

Mercredi 3 mai 2017

The committee met at 1232 in committee room 1.

PROTECTING PATIENTS ACT, 2017
LOI DE 2017 SUR LA PROTECTION DES PATIENTS

Consideration of the following bill:

Bill 87, An Act to implement health measures and measures relating to seniors by enacting, amending or repealing various statutes / Projet de loi 87, Loi visant à mettre en oeuvre des mesures concernant la santé et les personnes âgées par l'édiction, la modification ou l'abrogation de diverses lois.

The Chair (Mr. Monte McNaughton): Good afternoon, everyone. Welcome to the Standing Committee on the Legislative Assembly. We're here to have public presentations on Bill 87.

DR. JODIE CALVERT WANG

The Chair (Mr. Monte McNaughton): I'd like to call upon Jodie Wang, if Jodie's here.

I'd also like to thank the committee members. I know we had a pretty tight schedule to get down here after the late question period, but thanks for being here as close to on time as possible.

Jodie, you'll have six minutes for your presentation. If you'd begin with your name, please, for Hansard, and you can begin with your presentation.

Dr. Jodie Calvert Wang: Good. Thank you very much.

My name is Dr. Jodie Calvert Wang. I am a family doctor in Kitchener. I have recently been elected to the council of the Ontario Medical Association as a delegate for district 3, Kitchener, and also as a delegate for the section of general and family practice. I am also speaking today as a member of the grassroots groups Concerned Ontario Doctors and Doctors for Justice.

I thank you for this opportunity today to address the standing committee about Bill 87, the Protecting Patients Act. This act, if passed, is going to lead to disastrous outcomes for both the patients and the doctors of Ontario.

From the beginning of family medicine residency, we are taught that the foundation of family medicine is the doctor-patient relationship. Patients know that they can trust their doctor to keep their confidences and not to judge, to be there for them when a crisis erupts, to provide their medical home base in a confusing health care system, and to advocate for them when they are battling with their employer or insurance company over health issues.

I am privileged to hold a special place in my patients' lives. I am with them when a new baby is brought into the family and when they receive the news that their child has a life-threatening illness. I am with them when they suffer a marriage breakdown, or a work crisis and need time off. I hear their stories when they are struggling to deal with an aging parent or a drug or alcohol dependency. It is a powerful and precious role, and the cornerstone is trust.

This bill will erode that trust and place the doctor-patient relationship in jeopardy. By making doctors practise defensive medicine, we will have to stop focusing on the patient before us and start worrying about protecting ourselves. We will be avoiding sensitive topics and intimate exams. We will be replacing physical examination skills with expensive imaging and testing. We will be shifting our focus from our patient to self-protection.

In a large and varied practice such as mine, there is always a subset of patients that already stimulate fear. While not necessarily physically violent, there are patients who use threats and bullying tactics to intimidate me and my staff. Their demand may be for narcotics, but it may also be for something as simple as a CT scan or a test that they are convinced they need. My duty to practise responsibly and not squander public resources often leads me to have to refuse these demands, and then I am faced with trying to mitigate this fallout.

It is not uncommon for me to hear the threat, "I am lodging a college complaint against you," because I have displeased someone. As it is, patients are already free to complain online on rate-doctor forums and to damage our reputations without any ability to tell our side of the story. How much more power will patients now have once Bill 87 passes if they can lodge a spurious complaint and have my licence suspended immediately and my practice and livelihood shut down indefinitely?

I myself have faced a CPSO complaint which was completely fabricated. Even though I knew that my staff and my charts would eventually exonerate me, that did not lessen the sickening dread of seeing a CPSO letter marked "Confidential" appear in my mailbox, nor did it assuage the anguish of dealing with a stressful, drawn-out investigative process. The stress of a CPSO complaint is

easily comparable to the stress of being told that you have been chosen for a detailed CRA audit. Imagine, if you can, facing that anxiety every day.

No doctor speaking before this committee is objecting to harsh punishments for sexual abusers. No doctor speaking before this committee believes that any physician who actually commits such a heinous crime should ever practise medicine again, in any jurisdiction.

But this bill makes innocent doctors terrified. This bill, as written, makes doctors like myself, who would never even entertain such abhorrent thoughts, wonder if we can even carry on in such an atmosphere of fear. Many physicians I have spoken to have disclosed that they are going to stop doing intimate examinations that may place them at risk. Some physicians have said that they will be suspending reception and phone services to have their secretary sit in on more patient visits. One doctor even stated that he will be leaving the exam room doors open now, to protect himself from potential accusations.

I would ask this committee to imagine attending your own doctor and not being able to speak confidentially without one or more people listening in to protect the doctor from you. Imagine the damage to the doctor-patient relationship as doctors shift from focusing on the patient before them to focusing on how to protect themselves from losing their businesses, their homes and their livelihoods. This bill will corrode the trust that is the very foundation of family medicine. Doctors cannot build or maintain a relationship of trust with people of whom they are afraid.

A physician friend of mine had a charge of sexual abuse laid against him a few years ago. Rather than face the nightmare of a CPSO disciplinary committee hearing, he took his own life, leaving behind his parents, his wife, and several elementary-school-aged children. This week, two physician colleagues of mine, both outstanding members of the profession and both far from traditional retirement age, have announced that this final assault on physician dignity has been the last straw for them, and they will be closing their practices before summer.

It is already a well-documented fact that doctors have a far higher suicide rate than the general public, and now our mental health needs will go unaddressed—

The Chair (Mr. Monte McNaughton): Ms. Wang, that's six minutes. We're going to move to the official opposition and Mr. Yurek or Mr. Bailey for three minutes of questioning.

Mr. Jeff Yurek: Excuse me. Can you carry on with your remarks?

Dr. Jodie Calvert Wang: Thank you. Our mental health needs will be going unaddressed because this bill even strips us of our right to privacy with our own doctors. Why has this government tabled a bill that, instead of focusing on quickly bringing criminal doctors to justice, has rather taken broad strokes to subject the thousands of good and innocent doctors of Ontario to a reign of terror where we are guilty until proven innocent?

To discourage young graduates from pursuing family medicine does not serve the patients of Ontario.

To drive doctors out of the province, or to early retirement, does not serve the patients of Ontario.

1240

To escalate doctors' stress while discouraging us from seeking any mental health help due to loss of our own confidentiality does not serve the patients of Ontario.

Destroying the doctor-patient relationship and replacing it with suspicion and defensive self-protection does not serve the patients of Ontario.

Today, I ask this committee to give serious consideration to rescinding or amending this act. Focus, rather, on swiftly punishing the guilty, and leave the relationship of trust and goodwill that exists between doctors and their patients unmarred by fear. The patients of Ontario deserve nothing less.

The Chair (Mr. Monte McNaughton): Mr. Yurek?

Mr. Jeff Yurek: Thank you very much. Just a couple of questions, if I have time: What is the fix to this bill with regard to your concerns with the sexual abuse complaints process?

Dr. Jodie Calvert Wang: Well, I feel that the criminal justice system has to be structured in a way that it will quickly address these issues and very quickly come to a conclusion as to whether somebody is in fact guilty and is putting the public at risk, because of course protecting the public is the top priority.

Perhaps, if the CPSO had a way to be able to deal much more quickly with frivolous complaints, then they would have the resources and ability to address serious complaints like this and very quickly reach the conclusion of innocence or guilt. But, for physicians to be accused and then from that point have their licence suspended and have our names put on a public register or the public newspaper, I'm sure it's very obvious to everyone that that will be devastating to destroy one's reputation, even if you are found innocent.

Mr. Jeff Yurek: So in essence, the way you see the bill, many doctors are going to have to change their practice as physicians, which is going to decrease access to services. Will it endanger the health of patients of Ontario?

The Chair (Mr. Monte McNaughton): We have to move, actually, to the third party now. Mr. Vanthof.

Mr. John Vanthof: I like that question. So if you could answer the opposition's question?

Dr. Jodie Calvert Wang: No doctors want to do anything that puts their patients at risk. So if they are having concerns about their own safety, they will be either, instead of doing a physical examination, sending their patients for other expensive diagnostic testing or perhaps having to bring in a family member or other people into the exam room, even if the patient doesn't want that, and, in fact, that may discourage patients from coming to the doctor, if they know that they can't speak to the doctor confidentially or be examined alone, that they have to have somebody else in there with them

Mr. John Vanthof: That's fine.

The Chair (Mr. Monte McNaughton): That's it? Okay. We'll move to the government and Ms. Wong.

Ms. Soo Wong: Thank you very much, Dr. Wang, for being here today. The government has been dealing with the whole issue of self-regulation of the health care system, but also making sure the patient is safe—and the quality health care. Can you share with the committee, in terms of your remarks, how do we increase transparency—that's one—and strengthen the whole issue of the sexual abuse provision in the legislation? Because we have heard from the community and from your colleagues that we've got to address this issue, and there has been constant conversation about this. So can you share with us how do we increase transparency and address sexual abuse? Not all doctors are bad; we all know that. So how do we increase that piece?

Dr. Jodie Calvert Wang: Right. Yes, I mean, it's a small percentage of physicians that are guilty of such terrible crimes. Of course, it's obviously in the public's interest and in the profession's interest that those people be reported and very promptly investigated, and that a rapid decision as to innocence or guilt be reached. That's something that doesn't have to drag out over years to determine if there's evidence of somebody being a risk to the public. But, as this bill stands—to take an innocent physician and paint them with the same brush and say, "You've been accused of this. We're going to put your name in the paper. It's going to be on the public register, and you can't work until whatever time we drag through this case." Even complaints of a minor nature up before the CPSO can take two years to come to resolution. Physicians who are not guilty of committing any crimes would lose their practices.

You can't keep a practice open and you can't keep your patients with you for two years while you're not working. Your patients will all go elsewhere. Your business and your livelihood that you've worked, perhaps, 30 years to build up will evaporate overnight and, more importantly, also will your reputation.

If you're painted with an accusation of such a terrible crime, that's going to remain in the public's mind, even if it's eventually changed on the register to say that this person was found innocent. It's a foundation of our democratic society to be innocent until proven guilty.

Ms. Soo Wong: Okay, thanks.

The Chair (Mr. Monte McNaughton): No further questions?

Ms. Soo Wong: No.

The Chair (Mr. Monte McNaughton): Okay.

Thank you very much. Thanks for your presentation today.

Dr. Jodie Calvert Wang: Thank you.

CONCERNED PARENTS OF LONDON AND AREA—ON VACCINES

The Chair (Mr. Monte McNaughton): I'd now like to call upon Concerned Parents of London and Area—on Vaccines. Could you please come forward? If you would, begin by stating your name for Hansard. You'll have six minutes for your presentation, followed by three minutes of questioning from each party, beginning with the third party. Please begin.

Mr. Loren Baribeau: Okay, thank you.

Good afternoon. My name is Loren Baribeau. I'm representing the Concerned Parents of London and Area—on Vaccines. There are about 100-plus families in our little group.

Ladies and gentleman, we are in the middle of a health crisis. According to the Prime Minister of Canada in 2008, one in 10 Canadian children has life-threatening afflictions.

In the past 25 years, we have seen increases in the following childhood illnesses:

—allergies;
—anaphylactic food allergies;
—asthma;
—autism;
—attention deficit hyperactivity disorder;
—autism spectrum disorders;
—developmental delay;
—eczema;
—juvenile diabetes;
—learning disabilities;
—obesity; and
—severe mood dysregulation.

It is critical to understand that these dramatic changes over the past 25 years coincide exactly with the changes in vaccine scheduling. Just in the past decade, we have witnessed outbreaks of infectious disease among the fully vaccinated. We see new viral strains, rising rates in neurological disorders and increases in autoimmune conditions never before seen in large percentages of these children.

Since 1980, Canadian vaccine schedules have more than doubled the types of vaccines given. Public health authorities now recommend 32 to 41 doses of 13 to 16 different vaccines in the first 18 months alone. Some provinces start injecting babies at birth. By the time a child is six years old, he will receive approximately 49 doses of vaccines in an attempt to artificially boost immunity.

Presently, Canadian and American children are among the most vaccinated in the developed world, while showing some of the highest infant mortality rates in the industrialized world.

We are placing a monumental amount of trust in the companies developing these vaccines. Merck and Co., for instance, are currently in court battles in the states of New Jersey and Pennsylvania. Under whistleblower protection, they showed clearly that Merck and Co. have lied and destroyed and hidden data showing that their MMR II vaccines are not what has been claimed, with the efficacy being augmented by adjuvants and excipients used.

If vaccines didn't cause injuries, including autism, we wouldn't see the billions of dollars in compensation being paid out in the US by their vaccine courts to this effect. We have no statistics for compensation for vaccine-damaged Canadians, as currently there exists no such safety net for the children of this country. Likewise, we don't know the costs to taxpayers who are given the responsibility of looking after these damaged children.

The thrust of my presentation is on safety, which is the number-one reason parents seek exemptions. Parents are eminently more invested in their children than the government. Given that the government seeks to maximize vaccination rates, how realistic is it to expect fully impartial education sessions and no coercion?

My hope is to impart to you the gravity of these questions and, therefore, the gravity of the part you are now playing to affect either the relative ease or difficulty for parental choice to protect their children against the dangers inherent in vaccines.

Are vaccines safe?

If we can accept that vaccines are "unavoidably unsafe," as stated by the US Supreme Court, the question is, how unsafe are they?

The Cochrane Collaboration report from May 2011, after reviewing more than 65 clinical trials and studies on the MMR vaccine involving more than 14 million children determined that, "The design and reporting of safety outcomes in MMR vaccine studies, both pre- and post-marketing, are largely inadequate."

1250

Herd immunity is also a topic of conversation. It's the industry's justification for mass vaccination. In the original understanding of herd immunity, the protection to the population at large occurred when people contracted the infections naturally through human contact. Naturally acquired immunity lasts for a lifetime. Mothers who have measles as children pass this immunity on to their babies, protecting them while their immune systems mature.

Vaccine proponents quickly latched onto this concept and applied it to vaccine-induced immunity. However, it was soon determined that vaccine-induced immunity lasts for a relatively short time, from two to five years at most. Consequently, manufacturers began silently to recommend boosters for most vaccines, which were also discovered to last for only two years or less. While these vaccines are somewhat effective for a limited time, meanwhile they are decreasing the immune system's ability to fight other non-targeted diseases.

Vaccine-induced herd immunity is a faulty theory which alarms doctors, public-health officials, other medical personnel and the public into accepting vaccinations.

The bottom line with herd immunity is that natural herd immunity is genuine and valuable. Vaccine-induced herd immunity is an illusion and, being the justification for mass vaccinations, means there is no valid justification for mass, coerced or mandated vaccinations.

Regarding the medical information privacy violation proposed in this bill, it appears the objective is ultimately to track non-compliant parents. Not only does this violate privacy rights; it may lead to Big Brother surveillance on parents' choice regarding vaccines. Such a violation is unwarranted and unacceptable. It is critically important that we preserve the right for parents to obtain exemptions unhindered. Crossing this line into coercion and eventually mandatory vaccination is a violation on the scale of a human rights violation.

I ask, on behalf of my family, my children, my grandchildren and the 100-plus families of London and area we are here representing, that you remove the clauses pertaining to mandatory education sessions and the sharing of private medical records without consent.

The Chair (Mr. Monte McNaughton): Thank you very much. That's right on the six-minute mark. We'll begin the questions with Mr. Vanthof.

Mr. John Vanthof: Are there particular vaccines that you're more concerned about, or just the general thrust of the legislation?

Mr. Loren Baribeau: If you look at the scientific data, the vaccines themselves, if we look at the immunogenic properties—like the measles or the mumps virus or things we're trying to protect against—that really isn't the issue. I think it's the adjuvants and the excipients, the added detergents and preservatives and microbiotics that allow for the mass production of these vaccines.

It has becoming increasingly clear in the medical and scientific literature that it is these adjuvants and excipients—the aluminum and formaldehyde and caustic substances—that are causing the neurological damage in these young babies, because their brains are immersed in, basically, a toxic soup. It's small amounts, they say, but it's over and over and over, and it's building up. There's quite a bit of evidence out there showing that it is causing demyelination and problems in the development of a healthy nervous system.

Mr. John Vanthof: No further questions.

The Chair (Mr. Monte McNaughton): We'll move to the government. Ms. Wong?

Ms. Soo Wong: I'm just going back to your concluding remarks. You asked the committee to remove the clauses for mandatory education sessions. My question is: You and your organization are opposed to any type of education session so that parents can learn more about the vaccines. I need to get more understanding. Why is your organization opposed to being informed, being educated on vaccination?

Mr. Loren Baribeau: I think this point was being made with almost the fear of not enough public input or discussion on what these mandatory educational sessions are going to include, the fear being that it's going to be a lopsided, possibly—I don't know if I can use the term—big-pharma approach to selling more vaccines. Parents are afraid that these educational sessions are not going to be fully informed with the risks inherent and the benefits inherent in what basically is a medical procedure.

I'm not against the educational sessions. I'm actually looking for either input into these educational sessions—I can't for the life of me find what is planned for these sessions or what kind of information or who's providing it. It's not that we're against informed people. The reason, really, why we're here is to inform people.

The Chair (Mr. Monte McNaughton): No further questions? Okay.

We'll move to the official opposition and Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in today. It's good to see you here.

With regard to the mandatory educational sessions—and I would assume that someone like yourself would be forced to go to these mandatory sessions—do you think anything brought forward from the health unit would change your mind with regard to your thoughts on vaccinations?

Mr. Loren Baribeau: Well, I may not be a good cross-reference out of society to ask because of the thousands and thousands of hours that I've spent here—I have a neurological background with a Bachelor of Science in neurobiology. Therefore, maybe my insights into it are a little more than the average person's. It would be difficult to convince me that these adjuvants and excipients that are used in the necessary process of mass vaccinations—it would be very difficult to convince me that taking formaldehyde, a known cancer-causing substance in inhalation and ingestion, and then somehow we can inject it into a human being and it's no longer cancer-causing? For me, that would be a leap of faith, and I couldn't do it because I've researched it too much.

Others, maybe, could accept it. But these aluminum adjuvants and formaldehyde and these kinds of what they call necessary detergents and preservatives to allow the distribution of these vaccines over large areas of space—that's a necessary risk. So let's tell the parents that it is a risk, and let them decide if it's a necessary risk.

Mr. Jeff Yurek: So your one request if the government goes forward with mandatory education is to have both sides of the story at these sessions?

Mr. Loren Baribeau: Yes. I would like to sit down—or whoever—with the communities that should discuss this, including the medical communities, because I have a lot of doctor friends, through sports and things and social outings, who have never read a vaccine insert. They have no idea that the adjuvants and excipients used contain these chemicals. I doubt very many people in this room are aware of what is actually in these and why we are seeing this huge rise in all these neurodevelopmental diseases and things.

There are scientists out there who have eloquently elucidated the cause for it. Dr. Russell Blaylock, for instance, has set out the pathways and shown how the aluminum activates the cytokines and the astrocytes and the glial cells in the central nervous system and is causing this damage. But to get this information out to the public is very difficult, because vaccinations are the Holy Grail.

I don't want to put anybody off. I'm not a crazy man. I've done some research and there is science there that they're asking for.

The Chair (Mr. Monte McNaughton): Thank you very much. The three minutes are up. Thanks for your presentation today.

Mr. Loren Baribeau: Thank you for giving me this opportunity.

COLLEGE OF MIDWIVES OF ONTARIO

The Chair (Mr. Monte McNaughton): We'll now call upon the College of Midwives of Ontario. Like the ones before you, if you'd state your name for Hansard, and then you can begin with your six-minute presentation.

Ms. Kelly Dobbin: Thank you for the opportunity to speak with you today. My name is Kelly Dobbin and I am the registrar and CEO of the College of Midwives of Ontario.

I am here today in support of Bill 87 on several accounts: first, in support of the shared commitment to eliminate sexual abuse of patients, and second, in support of increased transparency with respect to additional information shared with the public about our registrants and also with respect to information shared about college processes.

Regarding the sexual abuse of patients, our college, fortunately, has had no experience with prosecuting a sexual abuse matter. However, our registrants care for clients who have been victims of sexual abuse, and they are intimately familiar with the effects that a history of sexual abuse can have on one's overall well-being, and in particular, on one's pregnancy, labour and early postpartum. Our members are as invested in the goal to eradicate sexual abuse as the government is.

1300

In terms of making specific recommendations to strengthen Bill 87, we trust the operational expertise that our college colleagues have attained in the years of prosecuting such cases and thus have supported the written submission made by the Federation of Health Regulatory Colleges of Ontario. We urge you to fully consider FHRCO's submission as it highlights some important areas where the proposed bill could result in negative unintended consequences.

We value consistency in our procedures and, therefore, we are in favour of the minister's intention to appoint an expert adviser to develop a framework for investigation and prosecution of sexual abuse cases and would welcome the opportunity to work with this person.

We support increasing access to funding for victims of sexual abuse by health care professionals and applaud the fact that colleges do not need to first make a finding of guilt in advance of releasing those funds. This is truly patient-focused and most respectful of victims.

We support the bill's intent to expand the definition of sexual abuse for which a health professional would face mandatory revocation; however, we encourage you to consider going further, beyond the objectified body parts listed in the proposed bill. Sexual touching of any body part should result in mandatory revocation. Personally, I find the sexualized stroking or kissing of a body part by a health professional to be as offensive as the touching of buttocks or breasts. The focus should not be on body parts but rather on the egregious violation of trust.

With regard to the definition of a patient and the proposed timeline of one-year post-patient interaction, this is consistent with our college's current policy. Our members deliver care that has a clear end date. At six weeks postpartum for both mom and baby, those clients are discharged from care. The one-year timeline prohibit-

ing sexual relationships to mitigate the power imbalance that is inherent in a professional/client relationship works in our case.

However, we appreciate the challenges this definition creates for other health professionals who provide episodic or one-time care and, more importantly, for those who offer psychological services, where this definition does not go far enough.

In support of increased transparency, our college undertook bylaw changes over a year ago to increase the information made available about our registrants on our public register. Our college already makes the information listed in Bill 87 publicly available. We list additional information as well, including charges, bail conditions, and convictions. We see this as a clear demonstration of our full support on this issue.

In summary, we applaud the minister in introducing this bill and support its intent. We urge you to take the time needed to fully consider the recommendations made by FHRCO, and individual colleges as well. I only ask that you don't move too quickly so as not to consider your best options.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll begin questions with the government and Ms. Kiwala.

Ms. Sophie Kiwala: Thank you very much, Kelly, for being here today. It's a pleasure to see you here. I'm very proud to say that my grandson was brought into the world by the Community Midwives of Kingston. I just had to give them a little bit of a shout-out.

Ms. Kelly Dobbin: Noted.

Ms. Sophie Kiwala: I have great respect for the work that you do. I have met with them in the community and I have met with the midwives here at Queen's Park as well. I have an enormous respect for your views on bringing children forth into the world. Thank you for that.

I do want to just highlight quickly the CMO council's public report from March 2017. I just want to read this into the record, your comments specifically, and thank you for them. You said, "The college fully supports the intent of the bill and, with regard to areas of transparency, has implemented many of the proposed changes over a year ago." We're very appreciative of that. "The college has also supported a formal submission from FHRCO to the Minister of Health ... identifying suggestions to better achieve the intended outcomes and to avoid unintended negative consequences." Again, I just want to reiterate our thanks to you for that.

You know that we are committed to increasing the transparency—and that's very much inherent in the bill—of health regulatory colleges and operations and empowering patients by enhancing their knowledge and education of the health regulatory system.

Can you speak a little bit more to the impact that you think these changes may have on Ontarians?

Ms. Kelly Dobbin: Yes, I think that Ontarians will be better informed about the health care providers that they are choosing to receive care from. They'll be able to make informed decisions based on increased information and relevant information about their health care provider. We wholeheartedly believe that the increased transparency is a benefit to Ontarians.

Ms. Sophie Kiwala: I'm wondering also if you could expand a little bit on how you see the RHPA improving protection of patients within the practice of midwifery.

Ms. Kelly Dobbin: I think I would say the same, that patients would be protected by just having more information. However, I also do support—which I didn't speak about in my submission—the issue of having the ability to suspend a member upon a finding of guilt of sexual abuse, and not having to wait.

The Chair (Mr. Monte McNaughton): That's the time. We're going to move to the official opposition and Mr. Yurek.

Mr. Jeff Yurek: Thanks very much for being here. You mention the timeline that they've set in the legislation: You're fine with regard to sexual relations with a patient?

Ms. Kelly Dobbin: Yes.

Mr. Jeff Yurek: I've spoken with CPSO. They have concerns with that timeline, the fact that under psychotherapy they think this should never, ever occur. There are other avenues where they think the timeline should be longer. Do you think a one-size-fits-all for all the colleges is going to work in this instance?

Ms. Kelly Dobbin: I do not. It happens to work in our case most of the time, with the way that midwives serve their clients. However, I am concerned that a one-size-fits-all doesn't address the issues.

I believe that our FHRCO submission also mentioned radiologists who don't have patient interaction, let's say, but they have the personal health information history of a patient and may not realize that they're actually developing a relationship with a former patient. I think that there could be criteria set out to better achieve the outcome of protecting patients from that inherent power imbalance, yes.

Mr. Jeff Yurek: Thank you. My next question is with regard to the new powers of being able to suspend a member on a complaint, I imagine probably as it's referring to an investigation committee: Is that something that's going to be automatic every time there's a complaint?

Ms. Kelly Dobbin: This refers to cases of sexual abuse. As I mentioned, we do not have a history of ever having prosecuted sexual abuse cases, so I would look to my colleagues and also look to working with the adviser that the minister is planning to appoint to set up consistent processes for dealing with those kinds of cases.

I would imagine that if we felt we had sufficient evidence that one of our registrants was sexually abusing a client or clients, then we would welcome the opportunity to be able to take swift and decisive action and protect the public in that way.

Mr. Jeff Yurek: Time?

The Chair (Mr. Monte McNaughton): Twenty seconds.

Mr. Jeff Yurek: Perfect. I like your message: "Don't move too quickly." We're rushing this bill. My concern is that something is going to be left out or something is not going to be addressed that needs to be addressed, so I really appreciate you making that comment. Let's take our time and get it right.

The Chair (Mr. Monte McNaughton): Ms. Gélinas?

M^me^ France Gélinas: Thank you so much for coming. I too appreciate very much the work that you and your members do.

I'm sorry that I couldn't listen to your full presentation, but I don't think you talked at all about schedule 2, the Laboratory and Specimen Collection Centre Licensing Act. Are there any worries at all from your members about the changes that we're doing to the lab?

1310

Ms. Kelly Dobbin: I am not commenting on that. However, I have been consulted on that change. We have our own submissions to make on that act that aren't related to this, but we don't have concerns about what's being proposed right now.

M^me^ France Gélinas: Okay. Where will that take place?

Ms. Kelly Dobbin: Well, we'll be working with our government colleagues to request a change to the lab act. We intend to request rescinding appendix B, which lists the labs that midwives may request. We would prefer to have midwives be able to access labs as needed, that are in the best interests of the patient, much like a nurse practitioner does.

M^me^ France Gélinas: Okay.

Ms. Kelly Dobbin: That's unrelated to this one in this bill, though.

M^me^ France Gélinas: Okay. The changes in the bill that change the power of the minister and the ministry to appoint people to your board and to your mandatory committee: You're all good with that?

Ms. Kelly Dobbin: Well, without seeing the regulation, I can't obviously comment on whether we're all good with that. I understand the intent, and support increased public participation on our committees and our panels. I do understand the challenges. We have a small council. We have five to seven appointed public members on our council and up to seven or eight professional members, elected members, on our council at any given time. We do understand there are challenges in finding public members to sit on our council at any given time, and when people's appointed terms come to an end, there is a waiting period to have that person replaced.

I do worry that if the numbers increase significantly, some of the smaller colleges with smaller councils may be impacted by having to delay proceedings if they don't have the adequate number of public members appointed.

M^me^ France Gélinas: I want to make sure that I heard you right, that—

The Chair (Mr. Monte McNaughton): Thank you very much. That's all the time we have. Thanks for your presentation today.

Ms. Kelly Dobbin: Thank you.

COUNCIL OF ONTARIO MEDICAL OFFICERS OF HEALTH

The Chair (Mr. Monte McNaughton): We're now going to have the Council of Ontario Medical Officers of Health present next.

Interjections.

The Chair (Mr. Monte McNaughton): And then we're going to go to Peel Public Health after. We're reversing them, if that's okay with the committee.

If you'd state your name for Hansard and then begin with your presentation. You have six minutes.

Dr. Vinita Dubey: Good afternoon. My name is Dr. Vinita Dubey. I am a public health physician and an emergency medicine physician. I'm here today in my role as an associate medical officer of health for Toronto Public Health and as a member of the Council of Ontario Medical Officers of Health, COMOH.

COMOH is made up medical officers of health and associate medical officers of health who are the physician leaders of the 36 public health units in Ontario. I am here to communicate concerns that our members have regarding schedule 1, the Immunization of School Pupils Act, and the mandatory provision of immunization information to medical officers of health.

We are very supportive of the government's commitment, through its Immunization 2020 plan, to ensure that public acceptance, availability and uptake of immunizations are improved through a high-performing, integrated immunization system.

Mandatory health care provider reporting of immunizations to medical officers of health will significantly reduce the need for individual reporting of immunization records by parents. Right now, the onus is on parents to report their child's immunizations to their public health unit. However, requiring health care providers to report immunizations directly to medical officers of health should only be fully implemented when the capability for seamless electronic reporting is in place.

In particular, we recommend the government accelerate efforts to integrate electronic medical record (EMR) systems from physicians' offices into the provincial electronic database used by public health called Panorama; and, secondly, that the government support mandatory reporting of immunizations given by physicians and other health care providers from EMR systems directly to the medical officer of health.

This will allow seamless and automatic electronic reporting of immunizations given to children zero to 17 years of age, directly into Panorama. Furthermore, these schedule 1 changes to the ISPA should not come into force until electronic reporting is available.

Interim solutions to mandatory physician reporting of immunizations should not be adopted, such as allowing physicians to fax immunization information, or adopting Immunization Connect Ontario, or ICON, which is an electronic portal for physicians to report immunization information to medical officers of health. These interim solutions will require manual entry or processing of immunization information by public health units. This is

time-consuming and inefficient and will result in delays for real-time immunization data. Interim solutions will also be time-consuming for the physician and will likely result in low compliance.

The New York City department of health and mental hygiene has had a mandatory health-care-provider reporting system for immunizations for over 20 years. Since 2008, all immunizations have been reported electronically and the vast majority transmitted by automated systems through EMRs. As a result, it has excellent compliance and very good immunization records, capturing 90% of immunizations given to children aged zero to 18 years.

The program started in 1996 with paper-based reporting, and experienced challenges with accurately matching patients to its registry, reconciling duplicate records, incomplete information, and expensive manual data entry. The completeness and timeliness of reporting improved when the primary method of reporting was automated from electronic health record systems. The compliance also improved because it was less burdensome for the health care provider to report. Ontario should learn from the experience of New York City.

Ontario already has experience integrating complex health information with EMR systems. OLIS, the Ontario Laboratory Information System, is an eHealth Ontario system to connect hospitals, community laboratories, public health laboratories and health care providers to facilitate the secure electronic exchange of laboratory test orders and results. As an integrated repository of tests and results, OLIS receives over 91% of laboratory tests performed across Ontario. In partnership with OntarioMD, eHealth Ontario has certified 11 EMR systems for access to OLIS data. To date, over 10,000 clinicians are receiving laboratory information from OLIS directly into their EMR system.

In summary, we are very supportive of receiving children's immunization reports directly from physicians and other health care providers through seamless electronic reporting by EMRs. It will be the closest Ontario has gotten to an immunization registry that has real-time data for children.

We hope that you will take these recommendations into careful consideration. We look forward to doing our part to assist you in meeting the strategic framework of Immunization 2020 to better the health of all Ontarians.

We agree that immunization is one of the most successful and cost-effective health interventions available, and our members remain its most vocal advocates.

The Chair (Mr. Monte McNaughton): You had one second to spare, so you did very well. We'll move to Mr. Yurek.

Mr. Jeff Yurek: Thanks, Chair. I'll take that second.

Thanks very much for being here. I appreciate your submission and your speech. It speaks to what I spoke about in the House. It's frustrating to see that the government has spent $8 billion on eHealth and a couple of hundred million, I think, on Panorama, and we still don't have this technology working to make this seamless.

I can just see, with doctors' offices, pharmacies, nurses and schools doing vaccinations, that coming in via fax or mail is really going to cause some headaches, especially in large areas like Toronto and Peel and Brampton. I appreciate the fact that you're saying to hold off until it's actually working.

1320

From your experience that you did talk about, do you have any idea of how much person-power and money it would take to implement inputting all of this data?

Dr. Vinita Dubey: Through a manual entry process?

Mr. Jeff Yurek: Yes.

Dr. Vinita Dubey: Right now, records are manually input. They're collected at the time a child enters school, until they finish school. This legislation will require records be collected from birth and after every immunization. So, for each child, it's that many more records of data entry, and the manual data entry burdens will be significant for health units. It will also be a significant burden for health care providers to provide that in the manual process to public health units.

Mr. Jeff Yurek: Thank you. I also think, as a parent—my daughter is in grade 7 this year, so she's getting an abundance of vaccinations at school, not that she's happy about it. But when I send her to camp this year, they always want an upgraded vaccination schedule. It would be so easy if parents had access to the data instead of me having to call the health unit and to have some sort of printout. If something was misplaced, it wouldn't be up to date, and I, as a parent, have probably thrown out that receipt they sent home to tell me that she was updated.

I think moving forward with electronic medical records and allowing access from the patient side of things at the same time is going to make the system better. But I agree with you that at this time, until the government gets their act together and gets the system working, I think that needs to not place the burden on health units, doctor's offices, pharmacies and nurses.

The Chair (Mr. Monte McNaughton): Great. Did you want to comment?

Dr. Vinita Dubey: Just to say that the immunization record is a really valuable record. We consider it a keepsake. Right now it rests with the parent, but not even just when you go to camp, not when you go to school. We've seen it with outbreaks, with our current outbreaks that we have of measles in Toronto—we ask people to update their records, check their records. Finding records can be an extremely challenging process for individuals.

The Chair (Mr. Monte McNaughton): Madame Gélinas.

M^me^ France Gélinas: My first question is: It came as a surprise that now the lab results from the health unit are available to health care providers and the community.

Dr. Vinita Dubey: Correct. The OLIS system, as I understand it, is being rolled out in different processes, but in health units, health units can also access laboratory records, as can some community providers and hospitals.

M^me^ France Gélinas: As can "some." Okay, that's not the focus of my question. You said we shouldn't go

ahead. How long do you figure before reporting of vaccinations could be done through the electronic medical record, and what stands in the way of having this available now?

Dr. Vinita Dubey: I think those are very good questions for the government and certainly questions that we would pose. We would certainly support having this available sooner rather than later because it would provide a very important immunization registry for all children in Ontario, which is something that public health systems have asked for and have recommendations for throughout Canada. But the timeline for the government to be able to implement that—I can't comment.

M^me^ France Gélinas: Okay, but you're a willing and able partner if and when this comes?

Dr. Vinita Dubey: Exactly, and we would certainly be supportive in any way to be able to spearhead this, to work as a partner, to be able to make this happen.

M^me^ France Gélinas: How well is Panorama working?

Dr. Vinita Dubey: Panorama is right now a very, very good tool. Our previous tool was a DOS-based system that was very antiquated. Panorama is a welcome tool next to that. There's a lot more functionality in Panorama that we can probably tap into in the future, and so I think this is one example.

M^me^ France Gélinas: And so right now your only connectivity to the primary care system, let's say, is through your lab results?

Dr. Vinita Dubey: I can comment especially for immunizations. Right now there is no electronic connectivity to immunizations and, in particular for the immunization system, it would be really valuable. But eHealth Ontario is a much broader strategy and I would not want to speak inappropriately on it.

M^me^ France Gélinas: That's okay. My last question, and I hope you'll have time to answer, is that we have parents that come forward and say, "Why is it that only people who object have to go through training at the health unit?" What do you answer to those parents?

Dr. Vinita Dubey: I think training is a form of informed consent. Every medical intervention has potential for harm. For vaccines, we know that they work, and we know that the benefits outweigh the risks.

The Chair (Mr. Monte McNaughton): We're going to move to the government. Ms. Wong.

Ms. Soo Wong: Thank you very much, Dr. Dubey. I see that you wear both hats: Toronto Public Health and ALPHA. I was a member of both of those organizations.

I want to ask you, just further to Ms. Gélinas's question to you about the Panorama stuff: How long do you think—because in your third recommendation, you said, "The ISPA should not come into force until electronic" records are available. What timeline are we talking about?

Dr. Vinita Dubey: My understanding, in discussions with the Ministry of Health through my working groups, is that it's within 2018-19; it's not a very long horizon. I think, rather than wasting resources on interim strategies, we should put all of our resources on the final solution.

Ms. Soo Wong: Okay, so you just want us to hold for a year while this is going on. What's your opinion, coming from Toronto Public Health—because I sat on the board for a number of years—how do we deal with it while we wait? We have schools that have a 100% and 150% turnover rate. Parents keep losing their immunization records. What do you say to those parents when you tell us to wait?

Dr. Vinita Dubey: Right now, we have a very good system in process for accepting records from parents for school-aged children. If we implement this too soon, we will be getting records from physicians, parents will continue to send us records, we will get many duplicate records, and we will have very much difficulty in inputting the data and we'll be backlogged. We may actually be worse off because we will not have real-time data in our system.

Ms. Soo Wong: Okay. So in your professional opinion, do you believe that the new, improved, integrated immunization system province-wide is the right approach that the government is going to be taking?

Dr. Vinita Dubey: Exactly. If we have seamless electronic medical record input of immunization data for children directly into Panorama that is accessible to public health units with no manual touching of the data, it will be a very good system.

Ms. Soo Wong: Thank you.

The Chair (Mr. Monte McNaughton): Any other questions from the government? Thank you very much for your presentation.

PEEL PUBLIC HEALTH

The Chair (Mr. Monte McNaughton): We'll now go back and call upon Peel Public Health. Thank you very much. You have six minutes for your presentation. If you would begin with your name. The questions this time will begin with the third party when you're done.

Dr. Monica Hau: My name is Monica Hau, and I'm an associate medical officer of health at Peel Public Health, the second most populous health unit in Ontario. I'd like to thank you for the opportunity to address the committee today to share Peel Public Health's perspective on Bill 87's proposed changes to the Immunization of School Pupils Act in schedule 1.

Our health unit supports high levels of community immunization in many ways. Specific to schoolchildren, every year, our staff screens the immunization records of over 250,000 students in our region and sends out 45,000 notices of incomplete records to parents. An additional 15,000 records are submitted every year by parents for students registering for kindergarten.

We are very supportive of the proposed amendments to the Immunization of School Pupils Act under Bill 87, as requiring direct reporting from health care providers to public health units would greatly improve the current system, which requires parents to submit this information. However, we feel that the requirement for health care providers to report immunizations should only come

into force once there is established and widespread digital reporting capabilities from clinic electronic medical records to Panorama, the immunization information system for the province.

Ensuring that electronic medical records, also known as EMRs, can seamlessly connect before mandating health care provider reporting will improve the timeliness and ease of reporting, achieve high data-quality standards, alleviate confusion and the burden of reporting for parents, and decrease the workload for health care providers, their staff and public health units.

Under the Immunization of School Pupils Act, students are required to receive 11 immunizations, from birth to 17 years of age, that protect against diseases such as measles, mumps and rubella, unless they have a valid exemption. Manual reporting of immunizations by our health care providers to our health unit would result in a significant burden to all concerned parties. For example, from birth up to six years of age, there are at least seven visits to health care providers for immunizations.

1330

In Peel, the estimated annual birth cohort is 16,000 babies. The number of reports health care providers would be required to send and subsequently received by Peel Public Health, assuming that 98% of immunizations have been taken up, over a six-year period for one birth cohort would be an estimated 110,000 reports. This high volume of records should be reported in the most efficient and effective manner possible.

The immediately available reporting mechanisms pose many resource and feasibility concerns. If paper-based reporting by fax is implemented, this will add an additional workload for health care providers, staff and public health units. For example, we estimate that up to an additional 50% of immunization staff, on top of existing staff levels, would be needed for manual entry.

Anticipated challenges of a manual process include accurate identification, lack of real-time data entry, and incomplete reporting information. If manual online data entry through the proposed Immunization Connect Ontario website is used, data quality may be improved over a paper-based process, but it will still be a time-consuming task, as patient information will need to be individually entered. Subsequently, public health unit staff will still need to review and accept every report into Panorama.

Most importantly, neither of these manual reporting options would completely replace the parallel parental reporting process, since without digital reporting capabilities from EMRs, uptake by health care providers is likely to be low. This poses an additional challenge as, once parents hear that physicians are required to report their child's immunizations, some may assume that they do not need to respond to requests to provide or update a record.

Confusion about who is responsible for reporting could lead to loss of confidence in the public health system. Parents may become frustrated that their child could face suspension from school if they thought that their health care provider was going to be the one reporting to the public health unit and they did not, indeed, report.

Furthermore, with the additional workload of processing health care provider reports simultaneously with parental reports, health units must be adequately resourced to take on additional reports in a timely manner. Data entry backlogs could lead to delays in ensuring that students have up-to-date immunizations to prevent communicable disease outbreaks.

In summary, Peel Public Health looks forward to participating in a more integrated immunization information system in partnership with health care providers. However, we ask that the provincial government learn from the experience and perspective of local public health units, and only implement health care provider reporting of immunizations when EMR interoperability with Panorama is achieved.

The Chair (Mr. Monte McNaughton): Thank you. Madame Gélinas?

M^me^ France Gélinas: I would say that you bring forward something that I hadn't thought of. Certainly, that there will be a sixfold increase in the amount of reporting that will be done to the health unit as we change the system had not entered my mind, but you certainly made it clear: 110,000 reports for 16,000 live births? That's a huge increase in anybody's caseload.

I don't know how long you've been in the business of health units, but how confident are you that an electronic solution to this reporting is fast approaching? Have we got something being tested right now? Is this something that's about to happen?

Dr. Monica Hau: My understanding is that there is an intention to move towards EMR reportability with Panorama. I am not clear on the timelines.

I certainly do know the benefits from other jurisdictions, like New York City, that have implemented this for many years. The majority of their reportings from health care providers to their public health unit is through EMRs, and they achieve about a 90% information uptake based on this health care provider reporting.

M^me^ France Gélinas: So basically, although the system we have now is not perfect, you suggest that we keep what we have now until we're able to move to an electronic system.

Dr. Monica Hau: Yes. I suggest that we wait until the final, most efficient and effective method is available and then transition at that point.

M^me^ France Gélinas: Okay. My other question—the same as I asked but didn't get an answer: We have parents who come forward and ask, "Why is it that it's only the parents who oppose who have to go to the health unit and listen to the training?"

Dr. Monica Hau: I'm not sure of the complete background because it is a provincial government initiative, but I do think it is important that parents get a full understanding of the risks and benefits of vaccines. Given that there's a multitude of different information sources and misinformation that we know on the Internet, it's really

important that people have a good understanding from credible sources of the benefits and risks of vaccines.

M^me^ France Gélinas: How does your health unit intend to provide this education?

Dr. Monica Hau: My understanding, from initial teleconferences with the ministry, is, I believe they are looking towards an online immunization education module, but I think you would need to confirm that with the ministry.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to the government: Ms. Malhi.

Ms. Harinder Malhi: Thank you for your presentation. I wanted to ask you: With the amendments to the Immunization of School Pupils Act, it would strengthen the requirements to obtain exemptions from mandatory school vaccinations. Vaccinations prevent disease and they save lives and reduce health care costs. How do you see this amendment improving the overall health of young Ontarians?

Dr. Monica Hau: The mandate we have—I'm sorry. Could you repeat it?

Ms. Harinder Malhi: Some people will be exempt. They can exempt from certain vaccinations. So how do you think that impact the lives of young Ontarians with the exemptions being allowed?

Dr. Monica Hau: Well, that's the current system, is my understanding. Under the Immunization of School Pupils Act, there is currently an ability to achieve either a medical exemption or to file a conscientious or philosophical exemption. So that already exists, in my understanding. In our public health unit, for example, we know that the exemption rate is quite low, actually: 1.6% of parents choose to file a conscientious or a philosophical or religious exemption. While the rates are low, we want to ensure that we have a high immunization rate in our schools, which is why it's important to continue the screening process on an annual basis.

Ms. Harinder Malhi: Okay. Thank you.

The Chair (Mr. Monte McNaughton): Mr. Fraser.

Mr. John Fraser: How much time do I have?

The Chair (Mr. Monte McNaughton): About a minute and a half.

Mr. John Fraser: How familiar are you as an organization with BORN Ontario?

Dr. Monica Hau: I am responsible for the communicable disease division, so I do understand that BORN is an electronic registry as well for—

Mr. John Fraser: Is it Better Outcomes Registry and Network?

Dr. Monica Hau: Yes.

Mr. John Fraser: Every newborn in the province of Ontario—I think they had their millionth child. In Ottawa, they've developed an application, immunize.ca. Are you using that—

Dr. Monica Hau: CANImmunize.

Mr. John Fraser: Yes, which is a new product which is a better interface, but it would seem to me that there's an interesting opportunity there that exists with BORN as they're kind of a centralized network. They're essentially public health. They're population health; right?

Dr. Monica Hau: Yes.

Mr. John Fraser: I just wanted to ask you that question because I think there's great potential inside both of those things for immunization.

Dr. Monica Hau: Absolutely. The CANImmunize app enables parents to document their own immunization records so that they have it stored. There are currently pilot projects, I understand, with Ottawa Public Health, to try to transmit that information directly into Panorama. I think that's fantastic work and should continue.

The Chair (Mr. Monte McNaughton): Great. Any further questions?

We'll move to the official opposition: Mr. Yurek.

Mr. Jeff Yurek: Thank you for being here. Yes, I think you raise valid points of ensuring that patient records aren't lost and duplications don't occur if we wait until the electronic portion is functional.

You mentioned 98%. You're saying that 2% of the population basically doesn't get vaccinated. That's just a number you said.

Dr. Monica Hau: Yes, that's an estimate, because we know that our exemption rate is quite low. It's about 1.6% for the conscientious or philosophical exemptions that we get.

Mr. Jeff Yurek: Okay. That brings up part of my next question. I come from Elgin–Middlesex–London. We have the Elgin St. Thomas Public Health Unit. We also have the London health unit in mine, but I'll focus on the Elgin St. Thomas Public Health Unit. The amount of reports you do in a year is more than the population of my area. I don't think we'll be overwhelmed too much with reports. Mind you, they probably have fewer staff to deal with it. Your concern is that you're going to be overwhelmed with the paperwork, which is going to make it really difficult. At the same time, in speaking with the ministry about the educational program, they said they're going to probably do it online. Well, there's a huge segment of my area that doesn't have high-speed Internet. I think it's taken for granted in Toronto that you're blessed that you can have Internet anywhere and everywhere you want to be.

1340

Dr. Monica Hau: Right.

Mr. Jeff Yurek: And I'm sure northern Ontario is the same. Small health units are going to struggle to deliver the education program that they're mandated to do and people have to go to, and the large health units are going to be inundated with paperwork, which may cause patient problems down the road.

Your thoughts? Maybe we should slow down on pressing this bill through in the next week or two weeks? It seems to be plowing through the Legislature here.

Dr. Monica Hau: Certainly, our recommendations today are—we're very supportive of the move to do this reporting. We do think that it is an improvement over the current process, which expects parents to be the ones to report. We are in support of that. We just ask that this

particular section not come into force until the technological capabilities are in place for the physician-reporting component.

As to the provisions for the vaccine education modules, I believe that those are still in progress, so I can't speak to the final delivery mechanisms.

Mr. Jeff Yurek: Okay. Thanks very much.

The Chair (Mr. Monte McNaughton): Thank you very much. Thanks for your presentation.

Dr. Monica Hau: Thank you.

ONTARIO MEDICAL ASSOCIATION, DISTRICT 11

The Chair (Mr. Monte McNaughton): We now call upon the Ontario Medical Association, district 11, Toronto. Good afternoon. Thanks for joining us today.

Dr. Mark D'Souza: Good afternoon. Thanks for having me.

The Chair (Mr. Monte McNaughton): If you'd start with your name, please, for Hansard, and then you'll have six minutes for your presentation, with questions beginning this time with the government.

Dr. Mark D'Souza: Sure. Good afternoon. My name is Dr. Mark D'Souza. I thank you for the opportunity to address the standing committee today about Bill 87. I am presenting as the chair of district 11 of the Ontario Medical Association, which encompasses the doctors of Toronto.

Ontario's Liberal government is bringing in Bill 87, named the Protecting Patients Act, under the banner of protecting patients from sexual abuse. The name itself continues with the grand Liberal tradition of teaching us to see the surface of things and not the depth. Peering just below this façade reveals its darker ramifications for patient care.

With Bill 87 as is, after any patient complaint or allegation of a sexual nature, the College of Physicians and Surgeons of Ontario—the CPSO, our regulatory body—will post these details on a public website before any due process. The allegations are only removed after a finding of innocence. However, the reputation of the physician will already have been publicly tarnished.

Bill 87 also creates the possibility of interim suspensions immediately after an allegation, also without any investigation.

To impose decisions without a hearing, the right to respond and the provision of written reasons is a fundamental violation of the physician's right to procedural fairness and natural justice. This is assuming doctors have the same human rights as everyone else.

Finally, colleges are mandated to initiate funding for counselling for complainants immediately, yet again without any delay to ensure the allegation has any grounds. This actually incentivizes people to file complaints, true or not.

Bill 87 is dubbed "the guilty before proven innocent act" in medical circles.

Let me be clear: Doctors also do not feel the CPSO does nearly enough to bar sexual predators from practising. Yet painting all of us with the same brush, assuming guilt before innocence and denying us our basic right to a fair trial—a right we've had for centuries in our society—will have a multitude of negative consequences not only for doctors, but also for patients' access to quality and timely care.

Given the government's scorched-earth tactics, Ontario is already an unappealing place to practise medicine. This piece of legislation may be the final straw for doctors on the cusp of leaving the province, let alone the profession.

The CPSO has recommended that doctors hire chaperones in their practices, to be present for all clinic visits. In emergency rooms, male doctors like myself currently coordinate with a female nurse chaperone when examining any intimate areas of female patients. This absolutely has an effect on wait times. If nurses are asked to chaperone every single doctor-patient interaction, already intolerable wait times will skyrocket. In community clinics, doctors without a chaperone may refuse to examine patients: "I can only afford a chaperone on Wednesdays, so come back next week and I'll listen to your heart."

Is the public okay with wait times ballooning, or having another person in the room for every single health visit? Have you actually consulted with the public and told them that this is one of the consequences of this act, as is?

If there are chaperones hired specifically to observe, who will pay for them—government, patient or doctor? I think we already know the answer to this question, and with so many clinics already in the red—coincidentally, your government's favourite colour—the obligation to hire more staff will force even more closures.

Lastly, having chaperones present directly impacts patient care, yet patients never had an opportunity to have a say.

Many physicians will be so fearful that they will send every patient for ultrasounds, MRIs and CAT scans in lieu of physical examinations. These will all cause delays in diagnosis, unnecessary system costs and significant patient inconvenience.

And what of stewardship of resources? When the consequences of a frivolous complaint are so high and unmeasured, it will be all the more difficult to tell you the radiation of the test you want is not worth it, or the narcotics you want will be harmful. It's not like we have an opioid crisis in Ontario, right? Doctors will be in the ultimate Catch-22.

Another Orwellian feature of Bill 87 is the Minister of Health gaining access to all doctors' personal medical records. What purpose could this possibly serve and what has Eric Hoskins told you guys is the reason for this part of the bill? This will act as a significant deterrent for doctors seeking their own medical care, in fear of their personal health information being inappropriately shared.

A 2008 sampling of 3,200 doctors found that nearly a quarter reported a two-week period of depressed mood.

Today, 300 doctors in Ontario are on disability, the majority due to mental illness. Physicians just passed dentists as the profession with the highest suicide rate, double that of the general population.

Untreated depression will indeed put patients at risk of medical errors or substandard care. How can we best take care of you if we feel overextended, unsupported and, frankly, burned out?

One final piece of Bill 87 I wish to discuss is the new reporting requirements that those who administer immunizations provide information to the local medical officer of health. This imposes a greater administrative burden on a job that already, in general, has one hour of paperwork for each hour spent with patients. This is a breach of the representation rights agreement between the Ministry of Health and the OMA. Under article 3, all discussions about physician work and compensation must occur via those negotiations channels.

As the pieces of the jigsaw puzzle come together, the Ontario Liberal master plan on health care seems to indicate top-heavy command and control, with little regard for what transpires at the bedside. With a few key amendments, doctors would be completely supportive of Bill 87. None of us want our patients to be seen by sexual offenders. Unfortunately, this draconian bill has the potential to forever compromise the quality and timeliness of patient care. Reading between the lines, this is actually about control over doctors, bludgeoning us into a class of automatons instead of highly trained professionals. Short of chasing us with broomsticks literally out of the province, you have clearly shown us we are not wanted, appreciated or valued members of society.

As is, Bill 87 ultimately sacrifices patient care. For the sake of the patients of Ontario, the doctors of district 11 implore you to see reason and work with Ontario's physicians in the spirit of collaboration. We ask that you remember that health care is delivered at the bedside, not on paper, and that patients who never converse with doctors are put last.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to the government and Mr. Fraser.

Mr. John Fraser: Thank you, Dr. D'Souza. It's nice to see you again. I think I saw you last time on Bill 84. I want to thank you for your presentation. I am pleased to hear that you agree that there needs to be zero tolerance, because even if you look over the last week, I'm sure as a professional the things that you hear are not reflective of the vast majority of physicians and practitioners in this province.

I appreciate your comments in talking about different key amendments, but I want to focus on one thing that I'm having a bit of difficulty understanding. You said very clearly—and I have also read the OMA's presentation about the fact in the bill we're proposing more resources for people who make a complaint and victims at the outset of making that complaint. I'm having a really hard time getting my head around why that's a bad thing. If you could explain that to me, that would really be helpful. I don't know why that's a bad thing. Because you're saying that we shouldn't be doing that.

Dr. Mark D'Souza: I just want to first clarify the question. Are you talking specifically about the funding for patients of sexual abuse?

Mr. John Fraser: Patient services—funding patient services so there are more services available to people when they make a complaint.

Dr. Mark D'Souza: I'm not—

Mr. John Fraser: My understanding, what I heard you say today and what I read in the submission from the OMA, is that you don't want us to do that, and I don't quite understand why.

Interjection.

Dr. Mark D'Souza: I think that's the crux of it. That's not at all what we're saying, that we don't want—I'm not saying that there shouldn't be more resources for those patients, but who is paying for it? I do think that maybe it should be OHIP paying for it.

Mr. John Fraser: Sorry?

Dr. Mark D'Souza: Maybe it should be OHIP paying for it. But for certain, they deserve more resources.

Mr. John Fraser: Thank you.

The Chair (Mr. Monte McNaughton): We'll move to the official opposition and Mr. Bailey—Mr. Yurek?

Mr. Jeff Yurek: He has already spoken just a minute ago.

Mr. Robert Bailey: I've already spoken.

Mr. Jeff Yurek: Thank you very much, Doctor, for being here. There are some value points that we need to discuss further. What are you hearing out there among your colleagues with regard to Bill 87 giving the college the power to suspend or remove a licence as the allegation proceeds? You're talking about some leaving the province, but what other things are you hearing out there from providers?

1350

Dr. Mark D'Souza: I think, in one word, the biggest theme is fear.

Mr. Jeff Yurek: You mentioned here that the doctors are having to hire chaperones in their offices. Doctors' offices are funded through the services you provide, unless you're in a family health unit. Is there funding available to add extra staff to fee-for-service doctors or doctors in group practices?

Dr. Mark D'Souza: Generally not. If you are a community clinic, your OHIP fees pay for your overhead, so if and when this comes into effect, then the chaperones will be paid out of that overhead, with obviously decreasing margins.

Mr. Jeff Yurek: With regard to personal health information that you have mentioned, with government being able to access the personal health information of doctors, do you feel there will be an underground self-treatment, or do you think doctors will just try to deal with it themselves? As you said, the suicide rate is on the rise, or other disabilities.

Dr. Mark D'Souza: I think personally, for me, I would probably go to Quebec or Manitoba to try to see a

doctor there. I don't want my file accessible to the Ministry of Health. But speaking for other doctors, I get the feeling that they will try to go untreated.

Mr. Jeff Yurek: Do you see any purpose to why they need your health information?

Dr. Mark D'Souza: No, and I know the Q&A is me answering you guys asking the questions, but I'm still curious as to what the answer to that question is. What is the purpose?

Mr. Jeff Yurek: Okay. No, I'm concerned as well.

So what proposed solution would you have that would placate doctors with respect to not being immediately suspended due to an allegation? It's really a fine line to deal with, because we want those perpetrators, those people that are committing these crimes—that are attacking people, in my opinion—removed from practising.

Dr. Mark D'Souza: We all do, Mr. Yurek.

Mr. Jeff Yurek: So what would be a solution?

Dr. Mark D'Souza: I want to emphasize the word "expedited": an expedited process. For a sexual complaint, expedite the process. With the College of Physicians and Surgeons of Alberta, 55% of their complaints are done within 100 days. That's amazing. Expedite the process and then, afterwards, if the person is found guilty, heck, I will be there with you to throw that stone, proverbially.

The Chair (Mr. Monte McNaughton): Thank you very much. We are going to move to Madame Gélinas for questions.

M^me^ France Gélinas: I'm interested in what you just brought forward. So you are not against removing the licence; you're against removing the licence before a due process is available. So can you explain to me what a due process would look like—I know nothing about the Alberta thing, so I'm curious.

Dr. Mark D'Souza: I spoke generally about complaints in Alberta and not specifically sexual complaints.

M^me^ France Gélinas: Oh, okay.

Dr. Mark D'Souza: But I think the bill, as it stands, allows the college or the Minister of Health to suspend anyone just like that. A patient complains; the next day, you are suspended. I don't see any democratic country in the world having that process.

What I mean by "expedited" is that the process through which the college investigates is done as soon as possible and then, if they are found guilty—we are all in agreement; doctors are all in agreement—throw the book at them then.

M^me^ France Gélinas: Okay. I think you were here when some of the public health units were talking about vaccinations. Good idea, good direction, but don't implement it until the electronic health records or medical records of physicians can communicate directly with the database of the health unit so that you can report vaccinations that way. Is this something that you would support?

Dr. Mark D'Souza: Me personally? It sounds like a good idea on paper. I just think you should get the technology there and find a way to negotiate with the OMA proper on fee compensation for the doctors.

M^me^ France Gélinas: Okay. But you support the idea of not moving forward with a paper-based system until the electronic system is in place?

Dr. Mark D'Souza: It seems to make a lot of sense to me.

M^me^ France Gélinas: Okay. For personal information, I am with you 100%. I've always opposed breaches to somebody's personal health information. We see more and more bills coming forward that open peepholes into people's personal health information. You haven't got an answer as to why the minister needs that peephole and neither have I. I don't know who has the answer, but please come forward and tell us why we need to have what I call peepholes into our FIPPA legislation that protects everybody's personal information from being seen by anybody but the people within the circle of care. They haven't answered that question for me either, so you're not alone. We will keep asking it. If there are no answers, then there's no reason to do that.

Dr. Mark D'Souza: Thank you very much. I appreciate it.

M^me^ France Gélinas: Thank you for coming.

The Chair (Mr. Monte McNaughton): Thank you very much for your presentation today.

Dr. Mark D'Souza: Thank you.

ONTARIO COLLEGE OF PHARMACISTS

The Chair (Mr. Monte McNaughton): I now call upon the Ontario College of Pharmacists. Good afternoon. You'll have six minutes for your presentation. If you would each state your name for Hansard, please, then you can begin your presentation.

Ms. Nancy Lum-Wilson: Good afternoon. Thank you for inviting us today to provide comments on Bill 87. My name is Nancy Lum-Wilson. I am the CEO and registrar of the Ontario College of Pharmacists. With me today is Anne Resnick, our deputy registrar.

The Ontario College of Pharmacists is the registering and regulatory body for the profession of pharmacy in Ontario. My comments today are in reference to the RHPA found in schedule 4 of Bill 87.

As a regulator, our responsibility is first and foremost to serve and protect the interests of patients and the public. We strongly support the objectives of Bill 87 to strengthen the sexual abuse and transparency provisions of the RHPA. The amendments are appropriate and necessary and will assist the college in fulfilling our mandate.

It is our opinion that the changes to the RHPA strike a balance, providing legislative guidance for regulators, while also recognizing that individual health colleges have their own unique challenges that will be addressed within the regulations that govern each college.

This will help us to advance the intent behind this important legislation. For example, regarding ministerial direction on the composition of committees and panel structures, we welcome enhanced public participation. However, it is fundamental to the integrity of college

committees, and the incredibly important role that they play in serving the public, that clear competency criteria be established for both public and professional committee members. Currently, this clarity does not exist. The college looks forward to working with the ministry to establish how this can be achieved.

The definition of "patient" for sexual abuse purposes will also require further consideration by individual health regulators. Defining "patient" must reflect each profession's scope of practice and nature of contact between members and patients of each profession.

Within pharmacy, there are a number of practice settings and contexts in which professionals are employed. Some jurisdictions define a patient according to whether a member provides a service within the scope of practice, but this does not entirely reflect the types of potential contact between a pharmacy professional and an individual seeking advice. We believe that there would be value in prescribing criteria for defining "patient" for the purposes of sexual abuse.

For similar reasons, we also support the intent of the legislation to provide colleges with the option to extend the one-year time limit when a person will no longer be considered a patient. In some circumstances, a year or more may elapse between one clinical contact and the next. However, an individual may continue to regard himself or herself as a patient of that provider and would be troubled by contact that falls outside the expected interaction time limit.

Over the past two years, the college has made a concerted effort to make information about our role and our members easily accessible to the public through our website and our public register. The information contained on our website already exceeds the transparency requirements proposed in Bill 87. On our public register, we have included criminal charges, findings of guilt, and custody or release conditions. We have also added icon notifications to alert the public where there may be a noted finding following a complaint investigation or a discipline hearing. In addition, we post agendas, briefing notes and minutes of our council meetings. We continue to consider additional strategies related to advancing our transparency commitment to the public, and Bill 87 will support our work in this area.

There are also a few amendments that I would like to suggest to strengthen Bill 87 from a patient-protection perspective.

The college supports the proposal to provide earlier funding to individuals who may have been sexually abused, and to expand the types of expenses for which funding is made available. However, we would also like to continue to have the ability to provide funding to patients through alternative criteria that have been established by the college to support patients who are currently eligible for funding through this mechanism. This would exceed legislative requirements and provide our patient relations committee with additional options to support victims of sexual abuse. Based on our interpretation, Bill 87 would eliminate our ability to provide this additional support through the current alternative criteria.

We also welcome discussions on how changes to the Regulated Health Professions Act will necessitate similar amendments to the Drug and Pharmacies Regulation Act. The DPRA provides a framework for the college to regulate pharmacy practice sites in Ontario, including both community and hospital pharmacies. Aligning the two acts will allow the college to enforce regulations similarly for both the people who practise pharmacy as well as the environment in which pharmacy is practised, strengthening the college's regulatory influence and public protection mandate.

1400

The college looks forward to working with you as Bill 87 moves through the legislative process. We recognize that there are many questions as to how some of the changes to the RHPA may unfold, but we urge you to please consider the importance of working with the colleges to define these issues within the regulations.

The bill is important to Ontario's patients. It is also extremely technical. While supportive of the bill's overall objectives, a number of groups, including the Federation of Health Regulatory Colleges of Ontario, and other health regulators, have put forward a number of important recommendations for substantive change to the bill.

With respect, we suggest that the committee consider moving the clause-by-clause deliberation of the bill to a later date. We worry that the speed at which the bill is moving through the legislative process will compromise the ability of the committee and the government to consider feedback from the public. Moving the date would provide committee members and government with more of an opportunity to review some of the more substantive recommendations.

Our mandate is to protect and serve the public and patients. We share the government's objectives to strengthen the sexual abuse and transparency provisions of the RHPA, as well as improve the complaints, investigation and discipline processes. By working in partnership with government, the colleges will have the tools that we need to strengthen our regulatory oversight of pharmacies and pharmacy professionals, and to build on our long-standing commitment of putting patients first.

Thank you for the opportunity to present to you here today.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to the official opposition and Mr. Yurek.

Mr. Jeff Yurek: Welcome to your role. I dealt with Marshall for the last little while, and I'm glad to have you aboard.

Ms. Nancy Lum-Wilson: Thank you very much, Mr. Yurek.

Mr. Jeff Yurek: And, Anne, it's good to see you again.

Just for the record, I am a member of the College of Pharmacists, but—

The Chair (Mr. Monte McNaughton): I've heard that before.

Mr. Jeff Yurek: Anyway, I have a few questions. It's interesting that you brought up the definition of the

patient, because pharmacists can get themselves in situations—for instance, if I'm at the variety store talking to my friend and they've got a sick stomach, I'm going to give them my professional knowledge. Does that make them my patient, and for a year down the road, does that get me into trouble if we meet up somewhere?

Ms. Nancy Lum-Wilson: Well, that's the worry, right? Which is why, when we're looking at it, we're looking at both the time limit as well as perhaps criteria. Really, there are situations, as I indicated earlier, where there is a long period of time that lapses between a health professional seeing a patient and seeing them again.

When we're looking at this, we consider criteria perhaps as the best way to move forward, because the interactions between regulated health professions and their patients will be different in all situations.

Pharmacy is an interesting one because folks will walk into the pharmacy and ask me for information and advice as you're roaming the aisles. Yet, at the same time, they would be considered patients, right? So we really need to take a look at that criteria and how that could be developed to address some of those needs across all the regulated health professions.

Mr. Jeff Yurek: With regard to committees, the College of Physicians and Surgeons of Ontario is requesting that the government separate who they place on—like folks on the discipline committee and keep the executive committee within the control of the college basically to maintain consistency and/or control of self-regulation. Do you share the same view?

Ms. Nancy Lum-Wilson: From our perspective, we're really focused, as CPSO is, around the discipline and the investigations committees. While we believe that there is definitely opportunity that we can look at all of this through regulations, we do feel that it's important that we look at what the role of each one of these committees is and what the impact of what it is that we're going to be doing is. At the same time, though, we absolutely welcome public participation. At our college, we have recently included patients and public in some of our committees, going forward, as well. So we do welcome them.

Mr. Jeff Yurek: Do I have time?

The Chair (Mr. Monte McNaughton): Fifteen seconds.

Mr. Jeff Yurek: If you've got it, quickly, can you somehow submit to the group your explanation on expanding the strengthening role of the College of Pharmacists within hospitals? You mentioned that briefly, but if you could.

Ms. Nancy Lum-Wilson: Within hospitals? A while ago, I'm sure folks still remember the issues that happened around the chemo under-dosing, which actually was the impetus for the college taking on that role around hospitals. We continue to move forward with that now—

The Chair (Mr. Monte McNaughton): Sorry to cut you off. We're going to move to Madame Gélinas.

M^me^ France Gélinas: Please finish. I'm also interested.

Ms. Nancy Lum-Wilson: So we continue to move forward with that now, working with the hospitals and really beginning to work with them to understand better what it is that they're doing and how we can ensure that they are working within the framework and providing, I would say, an environment of pharmacy that makes sense and the processes are put in place and how they're using their staff are also put in place that makes sense in the best interest of patient protection.

M^me^ France Gélinas: Thank you. You talked about—and more and more colleges talk about—this definition of a "patient in 12 months" doesn't work for them for many, many reasons, and many are going toward criteria to describe what a patient relationship is and when it ends. Have you got such a list of criteria in your back pocket someplace?

Ms. Nancy Lum-Wilson: We don't have it in our back pocket, but we would actually take this to our patient relations committee for deliberation. They were actually instrumental in doing a lot of the work with us on the sexual abuse task force as that work was moving forward. So we would actually be working with them again to develop these criteria. For us, the patient relations committee is very instrumental in a lot of the work that we do, so we'd like to continue to work with them to develop that criteria.

M^me^ France Gélinas: Sounds good. Right now, the government's legislative agenda is that we do clause-by-clause on the 17th—

Ms. Nancy Lum-Wilson: On the 17th of May?

M^me^ France Gélinas: Yes, and then it's done. We go back. They have a majority government and it's done. The arguments that the minister uses is that we need to protect patients. We need to protect patients from sexual abuse. The bill is there to protect patients from sexual abuse, but from what I'm hearing you say, we could do a way better job of protecting patients from sexual abuse if we take the time—even if, you understand, that means that we won't sit again till September—wait till September to do clause-by-clause so that we have time to figure those things out, get our lists done and do a good job rather than get this out the door on June 1 with all of the flaws in it?

Ms. Nancy Lum-Wilson: So, from our perspective, we think that—well, as you've already heard from the Federation of Health Regulatory Colleges of Ontario, there are some issues perhaps in some of the drafting and how the wording out there has been drafted right now. We would like, obviously, to have that time for the government to consider all of that, as you said, to do it right. I think that's very important because this is in a very important piece of legislation.

M^me^ France Gélinas: Even if that means it won't pass third reading till September?

Ms. Nancy Lum-Wilson: Recognize that, and as a college, for us, we have tools in place now that are helping us to do our job and to do it well.

The Chair (Mr. Monte McNaughton): We're going to move to the government, and just before I say that, just

to clarify: Clause-by-clause is May 17 and 31, those two days.

We'll move to the government and Ms. Wong.

Ms. Soo Wong: Thank you very much, Mr. Chair. My question to you, through the Chair: The government is committed to dealing with the whole issue of strengthening sexual abuse provisions and improving complaints. How do you see your college in terms of these proposed amendments that will improve patient care in terms of safety? And then the transparency piece, because we have been hearing these concerns for a long time.

Ms. Nancy Lum-Wilson: So could you clarify?

Ms. Soo Wong: You know, the government has been pretty up front about being committed to improving the transparency and the whole issue of sexual abuse provisions in the legislation. I want to ask you, from the College of Pharmacists' perspective, how do you see these proposed amendments that will improve both patient care and the integrity of your profession?

Ms. Nancy Lum-Wilson: I think when it comes to transparency, as I've indicated earlier, we are already exceeding all of the proposed amendments around the transparency, and we continue to do so.

As a college, we are truly committed, obviously, to the patient and to protecting the patient first. As we move forward, we continue to bring more patients and the public into our discussions. We believe that some of the changes that are being recommended will help us to do that. We really welcome public participation.

That being said, though, we also recognize that it's important that we base public participation and committee participation on skill sets, criteria, competencies and the availability of time, because we actually use our public members quite significantly and often—well, I wouldn't say often, but there have been times when due to time we've had to not have a panel sitting, have things cancelled, etc. If we have an ability to have more public members appointed, that will be very helpful for us.

Ms. Soo Wong: Okay. Thank you.

The Chair (Mr. Monte McNaughton): Any other further questions? Thank very much for your presentation.

Ms. Nancy Lum-Wilson: Thank you.

1410

ONTARIO MEDICAL ASSOCIATION—EMERGENCY MEDICINE SECTION

The Chair (Mr. Monte McNaughton): We'll now all upon the Ontario Medical Association, emergency medicine section.

Good afternoon. If you'd state your name for Hansard, you have six minutes for your presentation. The questions will begin with the third party.

Dr. Cristina Pastia: Good afternoon, and thank you for giving me the opportunity to present to the Bill 87 standing committee today. My name is Cristina Pastia. I'm an emergency physician at Michael Garron Hospital in Toronto. I'm here today to present my concerns with regard to Bill 87, representing the section on emergency medicine of the Ontario Medical Association.

To start, I'd like to assure you that as a physician I am fully supportive of legislation that puts our patients' well-being at the forefront. However, I have two main points of concern with regard to sections in Bill 87 which I will address today:

First, certain provisions in Bill 87 use vague language and leave grey areas which can profoundly affect the integrity, reputation and livelihood of physicians. Specifically, the bill, as it addresses sexual misconduct, states, "The inquiries, complaints and reports committee ... may ... at any time following the receipt of a complaint ... make an interim order directing the registrar to suspend ... a member's certificate of registration...."

This provision essentially assumes that a physician is guilty of an alleged sexual contact and has to prove his or her innocence. It is very difficult to understand how, without any evidence of a pattern of behaviour, a physician's right to fair and due process could be fully negated by only one allegation.

The gravity of having one's licence suspended places unjust hardship on the physician and goes against procedural fairness. It leads to loss of income and reputation, with no clear prospect of recovering either one if the allegation is proven to be wrong. The extent of a negative impact on a physician based on one allegation alone can be devastating.

Furthermore, there are provisions in Bill 87 which specify that the College of Physicians and Surgeons of Ontario would now be required to publish notices of allegation prior to a finding of professional misconduct. This is highly prejudicial. It also has long-lasting effects on physicians' reputations, given the public nature of the CPSO website and the long-lasting footprints of digital information.

Therefore, after an allegation is made, a physician is faced with the prospects of losing their income and reputation by having their licence suspended and facing public shaming by having these allegations publicized on the CPSO website.

It is cruel and ill conceived that legislation meant to protect patients risks such devastating effects on physicians, especially since we know that over 60% of claims in general against physicians end up being dismissed or abandoned.

What I am urging this committee to consider is the need for very specific wording in legislation. When such grave matters are considered, there is no room for grey areas. Doctor-patient relationships are, by their own nature, intimate. Patients need their physicians to be comfortable in fully examining them as clinically appropriate without being fearful of extensive negative impact from unproven allegations. Legislators should consider that the overwhelming majority of physicians are there to help their patients and protect them from all forms of abuse.

At times, individual patient-physician interactions can end negatively. As an emergency physician I can attest to

volatile situations with patients who become vindictive and threatening when their expectations are not met. Violence against doctors is unfortunately something that we do experience on a fairly regular basis. Emergency physicians are concerned that the current wording in sections of Bill 87 leaves the door open for false allegations of sexual misconduct by ill-willing patients. As a delegate physician to the OMA, my email has been inundated with comments such as, "I am a female physician and I am still really worried that an unstable psychiatric patient or someone with an axe to grind will file such a complaint against me. Previously, at least it would go through the usual channels and get dismissed, but now it's possible to get my name out there and my reputation ruined, and I would be out of work for 15 months."

General laws of procedural fairness and natural justice that govern our democratic society also apply to physicians, and they require physicians to have the right to present their case before actions are taken that impact their reputation and livelihood to such an extent.

My second point of concern relates to amendments to section 5 of the Regulated Health Professions Act which allow the minister to request reports containing personal information and personal health information of physicians without the express consent of physicians. This amendment gravely infringes on the privacy rights of physicians without any clear benefit to the minister.

As I understand it, this would be requested to establish if the CPSO is performing its regulatory duties. Surely there are other ways this can be determined without giving complete strangers within the Ministry of Health access to sensitive, private physician personal and health information. Given the vague language used in these amendments, there is no transparency as to which circumstances and what specific information would be shared.

Fear of this loss of privacy, which is protected under the Personal Health Information Protection Act, could lead physicians to not seek medical help for themselves. For a profession known to already have high rates of burnout and suicide, with a prevalence of depression amongst medical trainees three times the national average and the overall risk of physician suicide two to four times that of the general population, this would be disastrous. It is, in fact, not at all in the best interests of patients to have physicians who are reluctant to seek care for themselves. I am not sure how the government can justify legislating an infringement of such basic rights to privacy.

The Chair (Mr. Monte McNaughton): Great. Thank you very much. Madame Gélinas?

M^me^ France Gélinas: Thank you so much for coming and sharing with us some of the worries that you have identified in the bill. Would giving more time before the bill has actually gone through clause-by-clause and third reading—that is, we rise, we stop working here on June 1, we work in our constituency, and we come back at the beginning of September or mid-September. Would this pause be something useful to the OMA, to you and to the different sections, to try to work out the language that you would like to see, the changes that you would like to see? Is this something useful to you, or no?

Dr. Cristina Pastia: I think the time to analyze the vague language that we are concerned about—because, to be clear, certainly, we all applaud the desire to protect patients, but unfortunately it seems like the legislation, the way it's currently worded, has gone to the other extreme of the pendulum, where we have physicians with excellent reputations that can potentially be tarnished just by one simple allegation. That, I think, relates a lot to the vagueness of the language used. So if time is what it takes to address that vagueness and make it more specific—how exactly some of these changes would be implemented in the amendments of the legislation—I, personally, am supportive of that. It's hard for me to speak for the entire OMA. Certainly, I think, my colleagues in the section of emergency medicine would appreciate a thorough look into the wording, specifically, in order to not let physicians feel that they could lose their reputation over one allegation. It's easily done, and it only takes one physician.

M^me^ France Gélinas: Did you ever have an opportunity to ask the ministry why they want to create—I call it a peephole—this access into personal health information and how come they haven't found a workaround? Have you ever had someone answer that question for you?

Dr. Cristina Pastia: Personally, I've never had the opportunity to ask in person. I've read the legislation myself. I find it difficult to understand. I find the wording vague, and, again, there's a lack of transparency on what exactly the minister is looking for when trying to access what, quite frankly, is private information, and without consent. It's hard for myself and, I think, for physicians in general to understand that. So "no" is the answer.

M^me^ France Gélinas: Agree. Thank you.

The Chair (Mr. Monte McNaughton): Great. Thank you very much. We'll move to the government: Ms. Wong.

Ms. Soo Wong: Thank you very much for your presentation, Doctor.

I want to go back to a question I asked previous witnesses about the government's intention of dealing with the whole issue of self-regulated health professions. How do you see increased transparency and how do you address the whole issue of the sexual abuse provision? The government is making a commitment to improve that piece through this legislation. In your opinion—not all doctors are equal, as you can imagine—how do we increase that transparency but at the same time strengthen the whole issue of sexual abuse, because we hear it, front-page news, every day as MPPs. In this legislation, how do you address these two concerns?

Dr. Cristina Pastia: Right. So, again, the need for increased transparency and protection of patients, I'm fully supportive of. I think there are many ways of looking at the physician's code of conduct, starting—physicians who practise in hospitals mostly have chiefs

of staff, either in the department and then for the hospital. If there is a behaviour that is a concern, that usually becomes a pattern of behaviour. Of course, there's always the one first time that might be difficult to prove, and I understand that.

1420

The problem is that if you leave the door open for one allegation, and go after a physician after only one single allegation without looking at the prior conduct—if the physician's professional conduct is otherwise untarnished—you open the door for that physician to go through a very difficult time, for a long period of time.

While it might protect patients, the legislation, as currently worded, has gone to the other extreme of making physicians fearful for their reputation and for their income. It's difficult for those in the community—again, physicians have to report to the CPSO—

Ms. Soo Wong: Absolutely, absolutely. I know you made a comment, and other witnesses have spoken to concerns from the OMA dealing with the whole issue of collecting personal information and sharing public information. I understand that the ministry is looking at that piece, and I anticipate that those concerns have been heard by the ministry. I just want you to be assured about this piece, because we want to make sure that physicians who need help should get help, and that their personal information needs to be protected.

But I know that we also will be checking with the privacy commissioner, making sure that the legislation meets all of the existing legislation.

Thank you for your presentation today.

Dr. Cristina Pastia: I appreciate that. Thank you.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to the official opposition and Mr. Yurek.

Mr. Jeff Yurek: Thank you for being here today and raising the issues that you've raised. We've heard them previously.

What is the solution to this? I see the breaking point with doctors' support is the fact that they can lose their licence via an allegation about their conduct. How do we get around that problem?

Dr. Cristina Pastia: Again, like I was trying to explain, I understand the government has a fine balance between protecting patients without going to the extreme. The problem is that, as legislators, there's a lot of power. The power is in the words, and the vagueness of the words is our concern and my concern.

How you get around that, I don't know. That's why I'm a physician, quite frankly. But I'm just urging you to be quite careful in terms of not swinging the pendulum to the extreme. If physicians get harmed, in the long run patients also get harmed. If physicians become so fearful and emotionally distressed—we've talked about having to hire chaperones. In the hospital, in my department, we would have to use nurses all the time. Quite frankly, even as female physicians, when we examine patients, it drains resources. It has wider-spread effects that, I think, were possibly not initially anticipated when this legislation was worded in such a way.

As has been brought up before, expediting the process with any complaint when a patient feels that there has been misconduct, is certainly something we approve of, we sustain and we want to have happen. But physicians have to have a chance—at least, those who have never had any issues of misconduct—to provide proof that they might actually not be in the wrong.

I think it behooves the CPSO and the government to allow for that speedy process to happen in order to protect the patient but also, to a certain extent, the physician.

Mr. Jeff Yurek: In some professions out there, if they are charged with any wrongdoing and there's an investigation, they still receive their pay while they're suspended. That doesn't occur for doctors.

Dr. Cristina Pastia: If the doctor is not on a salary basis for some reason, that is correct. As long as you do not see patients, you essentially do not get paid.

Mr. Jeff Yurek: And if they're suspended, all of their patients no longer have access to—

Dr. Cristina Pastia: Right. These are the ramifications that I see. Not only will their specific patients have to wait longer, but you can imagine, even if the accusation is proved to be wrong, that there is a breach of trust. Things become public. It is difficult for the patients. Even if the physician returns, it might be difficult for the physician to reinitiate that patient-doctor relationship.

The Chair (Mr. Monte McNaughton): Thank you very much for your presentation today.

Dr. Cristina Pastia: Thank you.

MS. FARRAH KHAN

The Chair (Mr. Monte McNaughton): We'll now call upon Farrah Khan. Good afternoon.

Ms. Farrah Khan: Good afternoon.

The Chair (Mr. Monte McNaughton): If you would just state your name for Hansard before you begin, and you have six minutes for your presentation.

Ms. Farrah Khan: Sure.

The Chair (Mr. Monte McNaughton): Go ahead.

Ms. Farrah Khan: Great. My name is Farrah Khan, and I really appreciate the opportunity to speak today. I am a counsellor, advocate and educator on sexual violence. I've worked in the field for 17 years. I know I don't look like it; I get it. But I have. I'm currently the coordinator of the sexual violence office at Ryerson University and the co-chair of the provincial round table on violence against women.

I'm here because I want to first say thank you to the government for recognizing patient sexual abuse. It is a huge issue in Ontario, and something that advocates have been working around for two decades. We know this. I want to say thank you to Sheila Macdonald and Marilou McPhedran for their work around this especially.

I think we have to come together and say that the sexual abuse task force has done extensive work to really

bring this dire issue into light, but I don't think we've gone far enough. I think it's really important to say that Bill 87 is very important, but I think we can go further, especially to actually implement all of the recommendations from To Zero: Independent Report of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act, 1991.

I don't think that we can also think about this as a band-aid solution. We have to really see this as a systemic issue. If we want to further prevent sexual violence from happening to patients, we must take action to ensure that the relationship between a patient and the regulated health professional is built on a foundation of trust, safety and confidence.

Every day, I work to support survivors of sexual violence, be they faculty, students or staff. What I see is that they are fearful of going to health professionals if they've experienced sexual abuse by health professionals. It is so sad to see people who are in such a vulnerable state not knowing if they can go get help, if they can get a rape kit, if they can go get the support that they need, because they don't know if they'll be harmed again. We need to make this different. When sexual violence is left unaddressed in the health professions, not everyone will feel safe to access it. And isn't the point of universal health care that everyone has a right to access it?

I really think that this is about a commitment from the professional colleges, including social work, nursing, dentistry and doctors, to actively address the sexual abuse of patients in their ongoing training, in how they do investigations and in education and post-secondary programs. Within colleges and throughout the regulated health professional's career, there must be mandatory education on sexual violence, abuse, trauma, disclosure and the impact of trauma on the memory.

Trauma-informed care needs to be paramount in this work. We need to have it streamlined in all interactions with patients to ensure prevention of sexual abuse, but also to support the survivors who have been impacted by violence. We know that studies show that, globally, one in three girls and one in seven boys, before the age of 12, will be sexually molested. We know that sexual violence is rampant. It happens across the globe, and it's happening in Ontario. This is not just regulated health professionals; this is everyone. If we want to address this, we have to do this right.

Sexual assaults and other forms of sexual abuse by anyone, including health professionals, is absolutely and unequivocally unacceptable. We know this.

Within regulated health professional settings, there must be clear policies, procedures and protocols for addressing sexual abuse. That means that the moment someone discloses, we know what to do, we know where to go and we know the support is there.

When these protocols come about, they must be connected to the Occupational Health and Safety Act. They cannot just stand alone. They must be connected to policies and procedures that have already come into place. People have to have clear mandates of how they will address it and who will be notified. I know people can say, "Yes, we already have that," but they're not working, so we need to do it differently and better.

Additionally, we need to have bystander intervention training so that people in health care professions know how to address it, and when they see it, they know what to say. Within that, we have to recognize its contentious and political nature to name that sexual violence is happening in a workplace. How are we going to protect people who do blow the whistle and say, "I'm seeing a pattern of behaviour from a colleague. I'm seeing a pattern of behaviour by a group of doctors"? How am I going to protect that person who is being harmed, and also protect the person who says something?

I really applaud Bill 87 for removing the gender restrictions as a form of reprisal. It is very troubling to see that before, that somehow it would mitigate harm by just allowing a practitioner to provide service for one gender, as it stems from the assumption that sexual abuse is about desire, and not about power and control. The current gender restrictions allow for people to fall through the cracks and leave them unprotected from predatory behaviour.

As an advocate with survivors of sexual abuse, the provision I'm most excited about is one that will help patients increase timely access to funding for patient therapy and counselling when the complaint of sexual abuse is made. We shouldn't have to wait for someone to go through that to get the support that they need.

1430

The second piece I'm really excited about and that I hope goes through is the independent body for investigation of allegations of sexual abuse. It is very important that we have an independent body where people can go and get the support that they need. We know that marginalized folks—sex workers, women of colour, black women, people who are low-income, people who have struggled with mental health—especially are targeted for sexual abuse. Oftentimes, if they are going against a regulatory body that may not understand or may have prejudice and biases against them, they may feel fearful of coming forward.

When I grew up, in my family the number one thing you could be was a doctor, a lawyer or an engineer. I knew that in my family, if you went against that and said that a doctor had harmed you, you'd be seen as saying one of the worst things, like saying that a priest had harmed you—and we know how well that went. We know that this conversation is so important, to name this and to talk about how power and control dynamics go within this.

I also think that, post-investigation, there have to be proper repercussions for the acts of abuse committed. I think it's about increasing transparency as to what colleges must report on their public registries and websites, as well as requiring colleges to post council dates and materials on their websites in advance of each meeting.

I think it's important, too, that people have informed consent about what doctors and regulated health professionals have done in the past—

The Chair (Mr. Monte McNaughton): Time is up for the presentation. We'll move to Ms. Kiwala, from the government, for questions.

Ms. Sophie Kiwala: Thank you very much, Farrah, for being here. It's a pleasure to see you again. I don't know if you remember when we met previously at Queen's during the OUTA conference.

Ms. Farrah Khan: Yes.

Ms. Sophie Kiwala: I want to thank you enormously for the work that you've done over the past almost two decades. Can you believe it has been that long? It's amazing. You do look very young. Thank you very, very much for your advocacy that you have brought forward during that long period of time.

I also want to acknowledge you for being a leader within your own community. I won't spend my full few minutes just talking about how wonderful I think your work is. I'll move on, I promise.

I'm happy to see that you're supportive of the independent body, and very interested to hear some of the things that you've had to say, compared to some of the other comments that have come forward.

You clearly know what is happening on the ground, and understand the experience for victims of sexual violence, and that comes through very strongly in your presentation. The words "knowing what to say," for example, are key. Any time anybody comes forward in any circumstance, whether it is from an assault that has come from any of the professionals that you mentioned, it is important to know what to say, and it is those first words that pass in between two people that are critical.

We, as you know, are very committed to strengthening the sexual abuse provisions and improving complaints investigation and discipline processes for sexual abuse cases. You have a phenomenal amount of experience. Can you speak just a little bit more in depth, perhaps, to the importance of the measures for the safety of Ontario's patients?

Ms. Farrah Khan: I think it's phenomenal that the government is taking this on. I think that this is a hard conversation. It's not to lay aspersions on one professional regulated body over another. I think every profession has sexual violence happening in it. Everybody was talking about journalism two years ago, when Ghomeshi came out.

This is what's important: Ontario has to be a safe province. We have to be committed to the safety of all people. People who have been subjected to sexual violence should feel safe to go forward and say that something happened to them, to a body that actually is there to listen, to hear them, to get them the support that they need, and also to have an investigation that is separate from the body that regulates and supports the people who are doing the work.

I think it is really important. I think we can do more, so this is a start.

I do also recognize that we need universal precautions. That means that everybody be aware that sexual violence is happening, that we provide education around it—

The Chair (Mr. Monte McNaughton): We're going to move to the official opposition and Mr. Yurek for questions.

Mr. Jeff Yurek: Thanks for being here and giving your thoughts. It's good to have this side of the story at committee. It is giving us a balance of the effects on health care professionals. It's good to see the other side, and that's what we're trying to figure out, to ensure that we get this bill right.

Some of the colleges have been here, asking that we don't rush this legislation and maybe take a little bit longer into the fall to get this finally passed. Your thoughts on that?

Ms. Farrah Khan: It was 1991 when I first started reading about patient sexual abuse and the conversations about it. We cannot wait any longer. We have been told to wait too long. What are we going to tell the women and men and all genders who have come forward in 1991? That they should wait more? That their safety isn't as important? We cannot keep waiting. There's been fantastic important regulation information that's come forward from a lot of the research that's come forward. I know Sheila Macdonald and Marilou McPhedran have done phenomenal work with this. I know the task force has. We cannot wait, and safety cannot wait anymore.

I think the government and all government officials have taken this issue of sexual violence and been leaders—Ontario's a leader on sexual abuse and sexual violence right now. Let's continue to be that leader and promise Ontarians they have the right to be safe when they go anywhere, including to regulated health professionals.

Mr. Jeff Yurek: I think part of the legislation has a time limit for victims to obtain funding and support. Is there a time limit when someone should report and get help and support?

Ms. Farrah Khan: I don't think there should be all the time because I think it takes a long time to report. As a child sexual abuse survivor, I only started talking about my child sexual abuse when I was 16, and I was abused throughout my childhood. I can't imagine if it was somebody from a position of trust like that, as a doctor—I wasn't sexually abused by a doctor. But I think it takes a long time. Sometimes I do think it's important to actually open up the statute of limitations and not have them. It's important because it recognizes the impact of trauma on survivors. It recognizes the impact of the stereotypes and the stigma there is when you were abused, and so I think it's important actually to challenge that.

Mr. Jeff Yurek: Thank you. I do like your comments on whistle-blower protection. I think that's missing in a lot of our accountability and oversight in the system. Thank you.

Ms. Farrah Khan: Thank you.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to Madame Gélinas.

M^me^ France Gélinas: I was just curious to know: There was such a big gap in time between the time that

the minister's task force finished its report and the time that the bill came forward. Do you have any idea why this big gap happened?

Ms. Farrah Khan: No. No, but I do think that it's important that it has come forward and that we're moving forward on it. This has been since—let's be real, before the mid-1990s people have been asking questions about this. It's anybody in a position of trust, and regulated health professionals—I'm a social worker myself, in a regulated body; it is challenging to say something against any groups that have a lot of power.

M^me^ France Gélinas: Would you see those whistle-blower protections to be added to this bill?

Ms. Farrah Khan: I would love that, and I would love for us to look at a lot of the regulation ideas that have come forward and the task force recommendations.

M^me^ France Gélinas: Because a huge part of the task force recommendations are not being acted upon. Do we know if they're going to be acted upon at a later time?

Ms. Farrah Khan: I don't work for the government, but I do know that you can't eat an elephant in one bite, so I recognize that we have to do it as a stepped approach. What I think we have to do is make sure that we hold a commitment that we will eat the elephant one day and they will all be taken—all the recommendations—because that's what's important. So if you would push that forward, that would be great.

M^me^ France Gélinas: Absolutely. And a follow-up on the question that was asked to you before: You see another change in the bill where we don't put a time frame as to when a victim can have support provided by the college of the perpetrator?

Ms. Farrah Khan: I would think that would be great. The provincial government has already made that change for other forms of sexual violence.

M^me^ France Gélinas: Okay. Sounds good. Thank you.

The Chair (Mr. Monte McNaughton): Great. Thank you for your presentation today.

ONTARIO MEDICAL ASSOCIATION

The Chair (Mr. Monte McNaughton): We'll now call upon the Ontario Medical Association. Good afternoon. If you'd please state your name for Hansard and you can begin. You have six minutes for your presentation. The questions this time will begin with the official opposition.

Dr. Audrey Karlinsky: Thank you, Chair. I am Dr. Audrey Karlinsky, and I'm here today in my capacity as a member of the Ontario Medical Association board of directors. I am a family physician and a medical educator, and I practise here in Toronto. With me today is Dr. David Esser, also representing the OMA board of directors, who practises as a surgical assistant here in Toronto. Joining us is Dara Laxer from the OMA's health policy department, and Jennifer Gold, legal counsel and privacy officer at the Ontario Medical Association.

1440

Ontario's doctors support zero tolerance of any form of sexual abuse of patients. We must all collaborate to create a system that responds to allegations of abuse promptly and fairly, and that ultimately aims to prevent any act of sexual abuse from occurring in the first place.

For some, the fact that a very few physicians abuse their patients makes it easy to vilify the profession as a whole, and from here, it is a short step to losing sight of the basic tenets of procedural fairness that are the hallmarks of democratic societies. I ask you, as legislators, not to fall into this trap. Please do not equate attempts to ensure procedural fairness with a defence of sexual abuse or sexual abusers. They are not the same thing.

The importance of procedural fairness is underscored most notably when we consider the issue of false allegations. Groundless complaints are a sad reality, whether as a result of misunderstanding, mental illness or sometimes malice. Our judicial and quasi-judicial processes must balance the needs of complainants with the rights of the accused. False allegations have a devastating impact on a physician's emotional and financial well-being. It often takes years for complaints, even those of a sexual nature, to be adjudicated. In the meantime, reputations and lives are shattered.

Bill 87 allows for a licence to be suspended immediately upon the college's receipt of the complaint. An individual deserves the right to respond to a complaint and defend himself or herself before being penalized. Under Bill 87, even those who are innocent can be suspended without pay, and the suspension can go on for years. While this is very difficult for an employed professional, it is catastrophic for a physician running a small business, as you've already heard. Income disappears, but the costs of running a practice continue.

There are opportunities for improvement here. We have long known that the college's adjudication process takes too long. This was the subject of an inquiry by Justice Stephen Goudge in 2016. He made many recommendations for improvement. None of these have been incorporated into Bill 87. Adopting key recommendations from Justice Goudge as a part of Bill 87 would create a procedural environment that better meets both patient and physician needs.

My second area of focus relates to the penalties for sexual abuse. While the OMA supports clear and unambiguous penalties for sexual abuse, we have learned that many of our members are concerned about the provisions in Bill 87, and fear that all touching of breast, buttocks and genitalia could result in mandatory revocation of their registration. This is not the case, but it would greatly help if this committee were to put forward an amendment that clarified that the penalties refer to touch that is not clinically indicated—please—my emphasis there.

My final key point relates to the fundamental right to privacy that we all deserve as citizens of this province. Bill 87 gives the minister the authority to require colleges to collect personal health information about their mem-

bers. As you've heard from others, the minister can also compel colleges to disclose this information to the minister, in order to assure himself that the college is fulfilling its statutory duties.

It's entirely unclear to us why the highest levels of government need access to individual health records to monitor its arm's-length agencies. Surely the government can assess the effectiveness of colleges without breaching the privacy right of 300,000 Ontarians.

The OMA is willing to work together with you and other stakeholders to design a fair and efficient regulatory system that truly protects patients. Our written submission elaborates on the issues I raised today, and outlines other concerns that have been identified in our analysis of Bill 87.

I want to thank you for the opportunity to speak with you today. I welcome your questions and the opportunity for fulsome discussion.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to Mr. Yurek and the official opposition.

Mr. Jeff Yurek: Thank you for being here today and bringing forth your ideas. Hopefully, you'll submit the amendments to the committee so we can have a closer look at them.

As the association, what are you hearing out there, with regard to your members, on the fact that any allegation may result in the loss of their licence or the ability to practise?

Dr. Audrey Karlinsky: Right. As you can well understand, members are fearful of any unfair process that may result in revocation of their licence before due process has had a chance to be completed.

It's really more to speak to the unintended downstream consequences, Mr. Yurek—that physicians may now practise in a type of defensive form where they will delay sensitive or intimate examinations of patients until the chaperones are available, or even defer to diagnostic imaging, which will increase costs of delivering health care, in the place of a clinical exam when they feel that the patient may be unable to appreciate the difference between clinical touch and touch that is non-clinical in nature.

Mr. Jeff Yurek: Was the OMA consulted during the creation of this legislation so that you could give impact to what concerns you're raising?

Dr. Audrey Karlinsky: I'll let Ms. Laxer answer.

Ms. Dara Laxer: Thank you. No. There was no consultation with the Ontario Medical Association about this bill prior to first reading in December.

Mr. Jeff Yurek: With regard to access to privacy, I imagine there is more fear for your members, but do you have any idea what they need medical records for at the government level?

Dr. Audrey Karlinsky: It's the $100,000 question. Nobody in the room today has been able to answer it. I can really not understand, for the life of me, why the minister should have need of my personal health records in order to establish whether the college is doing its regulatory duties.

Mr. Jeff Yurek: Do you have any numbers or idea of how many groundless complaints are registered with the college? Is that out there?

Dr. Audrey Karlinsky: I'll let Ms. Gold answer.

Ms. Jennifer Gold: They don't release that information. We have tried to access that. We believe it to be quite high, especially in the realm of frivolous and vexatious complaints that come in, and there's currently no streamlined process for those. That's one of the things that Dr. Karlinsky mentioned: that we were really disappointed that, when the government decided to open up the Regulated Health Professions Act, they didn't decide to implement Justice Goudge's recommendations to streamline that process, thereby speeding up the process for things like sexual abuse complaints.

Currently, the volume of groundless complaints in the frivolous and vexatious domain is so high, it clogs up the system and backs up the more valued cases from—

The Chair (Mr. Monte McNaughton): We have to move to the third party: Madame Gélinas.

M^me^ France Gélinas: Continuing the same line, the Stephen Goudge report was commissioned by the ministry, but it seems like they sort of pick and choose what they want to listen to. If you want to continue your answer as to how things would be different if we take some of his recommendations and implement them.

Ms. Jennifer Gold: The two recommendations that we would really have wanted to see implemented in this piece of legislation would be the streamlining of frivolous and vexatious complaints, as I said, to speed up the process and to allow more important complaints to proceed quickly. We think that would be beneficial, not just to our physician members but to victims and patients as well.

We also believe that including Justice Goudge's recommendations for alternative dispute resolution would go a long way to speeding up the process and also helping to resolve conflicts and complaints between physicians and patients.

M^me^ France Gélinas: Would you be open to the alternative dispute resolution proceedings to be shared with the different colleges? Right now, colleges are reluctant to use this process because it is completely separate and they never get to know what was shared. Would you be open to that?

Ms. Jennifer Gold: We would have to consider it and look into the benefits and costs of such an option.

M^me^ France Gélinas: Okay. Thank you.

The Chair (Mr. Monte McNaughton): Great. We'll move to the government and Mr. Fraser.

Mr. John Fraser: Thank you very much for being here today and for your presentation. We very much appreciate the kind of consultative work that's going on right now.

I just have one really quick question. We had an earlier presenter; I put the same question to them. We just heard from Farrah Khan with regard to the importance of support for those individuals who are either victims or making a complaint, and that it's critical that we not

restrict that. Can you tell me why you think that would be important?

Dr. Audrey Karlinsky: Can you clarify? Why I would think—which element is important? Not to restrict?

Mr. John Fraser: That it's important not to restrict the access to those support services. In the proposed legislation, there's an expansion of that, and I believe that it's important. I think we share the same view.

Dr. Audrey Karlinsky: I would just say that, as a practising physician who works integrally with many other regulated health professionals, I would see no problem in getting timely access to supportive counselling and whatever health care any victim might require. I think it's really a question of how we proceed and who pays for it.

Ms. Gold, I think you had something you wanted to say.

Ms. Jennifer Gold: Yes. Of course we support timely access to therapy for victims. Our concern is: Who is going to pay for this access? The OMA believes it is unreasonable to ask the various health professions of Ontario to pay for health services, which we believe to be the government's role.

The Chair (Mr. Monte McNaughton): We'll move to Mr. Bradley.

Mr. James J. Bradley: I just want to commend you on an excellent presentation. It was professional, effective and helpful, and it provided a position to us. I want to contrast it with an earlier presentation which was made by the chair of district 11 of the OMA. I'll leave you a copy of his presentation. You will see the significant—

Dr. Audrey Karlinsky: We've heard it.

Mr. James J. Bradley: Yes, well, you will see the significant contrast between the manner in which you delivered your excellent message to this committee and the manner in which it was delivered previously by someone else.

The Chair (Mr. Monte McNaughton): No further questions? Okay. Thank you very much.

Dr. Audrey Karlinsky: Thank you all.

The Chair (Mr. Monte McNaughton): Thank you for your presentation.

The committee is adjourned until 12:30 p.m. on Wednesday, May 10, 2017.

The committee adjourned at 1451.

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