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Thursday 26 March 2009

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Jeudi 26 mars 2009

Standing Committee on Justice Policy

Comité permanent de la justice

Coroners Amendment Act, 2009

Loi de 2009 modifiant
la Loi sur les coroners

Chair: Lorenzo Berardinetti
Clerk: Susan Sourial

Président : Lorenzo Berardinetti
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Hansard Reporting and Interpretation Services
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON JUSTICE POLICY

Thursday 26 March 2009

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DE LA JUSTICE

Jeudi 26 mars 2009

The committee met at 0901 in committee room 1.

SUBCOMMITTEE REPORT

The Chair (Mr. Lorenzo Berardinetti): Good morning, everybody, and welcome to the Standing Committee on Justice Policy. The first item on the agenda is the subcommittee report dated March 12, 2009. Mr. Levac.

Mr. Dave Levac: Thank you, Mr. Chairman. I will put this on the record for the committee. It's a summary of decisions made by the subcommittee on committee business.

Your subcommittee on committee business met on Thursday, March 12, 2009, to further consider the method of proceeding on Bill 115, An Act to amend the Coroners Act, and recommends the following:

(1) That groups and individuals who responded to the committee's advertisement be scheduled to appear on Thursday morning, March 26, 2009, and on Thursday afternoon, April 2, 2009.

(2) That groups and individuals be offered 20 minutes in which to make a presentation.

(3) That the committee hold one day of clause-by-clause consideration on Thursday afternoon, April 9, 2009.

(4) That legislative research prepare a summary of all submissions heard and written submissions received.

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

So submitted.

The Chair (Mr. Lorenzo Berardinetti): Thank you. Is there any discussion? Motion to adopt?

Interjection: Agreed.

The Chair (Mr. Lorenzo Berardinetti): Thank you.

CORONERS AMENDMENT ACT, 2009

LOI DE 2009 MODIFIANT LA LOI SUR LES CORONERS

Consideration of Bill 115, An Act to amend the Coroners Act / Projet de loi 115, Loi modifiant la Loi sur les coroners.

DRUG SAFETY CANADA

The Chair (Mr. Lorenzo Berardinetti): We'll move on to our first deputation for the morning, Drug Safety Canada, Terence Young and Neil Carlin. Could you please sit up here? We've allocated 20 minutes for each presentation. Any time you don't use in your presentation, if there is time left over, will be shared between the three parties in asking any questions they may have. So you have up to 20 minutes. Yes?

Mr. Peter Kormos: Chair, if I may, you're too young to know this, but Terence Young was a very effective member of this assembly.

Mr. David Zimmer: Sorry, I can't hear you.

Mr. Peter Kormos: Mr. Young was a very effective—you're not too young to know it, but you may not have been here. Terence Young was a very effective member of this Legislative Assembly for a number of years.

Mr. Garfield Dunlop: Back in the days when they didn't leak the budget announcements.

Interjections.

The Chair (Mr. Lorenzo Berardinetti): Mr. Young, welcome back.

Mr. Terence Young: Thank you.

The Chair (Mr. Lorenzo Berardinetti): You know how this is going to operate, in terms of the presentation and the time allocation. Good morning and welcome to all of you. Please proceed.

Mr. Terence Young: Thank you. We thank the committee for the opportunity to present to you today. My name is Terence Young. I'm the founder and chair of Drug Safety Canada and author of the book Death by Prescription, which will be released on April 14, 2009.

We certainly support amending the Coroners Act. Three families represented here have been profoundly affected by deficiencies in the current act that are not addressed in the amendments. Each of us has lost a child, in each case a daughter, to an adverse drug reaction caused by a prescription drug taken as prescribed.

In March 2000, my daughter Vanessa fell dead in front of me. Her heart stopped after taking the prescription drug Prepulsid for bloating. She was otherwise very healthy, with no family history of heart arrhythmia. Prepulsid was known to cause heart arrhythmia, and eight infants had died during clinical trials. At the time, officially 80 people had died from heart arrhythmia while

on Prepulsid in the US, yet four doctors gave us absolutely no warning about the risks.

The fourth leading cause of death in Canada today is prescription drugs taken as prescribed in hospital, estimated at 10,000. As many as another 10,000 deaths likely occur outside hospitals due to prescribing errors, overdoses or patients taking the wrong drug. As many as one in four unplanned visits to our hospitals are related to prescription drugs. Serious injuries number in the hundreds of thousands.

How can this be? A series of critical loopholes in the Coroners Act help create a curtain of silence, protecting doctors and pharmaceutical companies from the consequences of giving patients harmful drugs, and betray the coroner's promise: "We speak for the dead to protect the living."

The first loophole is the coroners in choosing which deaths they will investigate. In 2000, I was warned it would be very difficult to get an inquest into Vanessa's death. Very few inquests are held under such circumstances, yet as a former MPP, frankly, I pushed my former caucus colleagues and I succeeded. I do not believe anyone without such personal contacts and connections would have been able to do so. The jury later made 59 useful recommendations to improve the system.

On the other hand, you've heard from the articulate and resolved mother of Martha Murray, Maryann, who sits beside me today. She worked for six years to obtain an inquest into Martha's death. It was delayed and put off repeatedly, unchallenged by elected officials until the coroner's office coldly terminated her appeals.

Beside me is Neil Carlin, whose daughter Sara died in May 2007 while withdrawing from the antidepressant Paxil. He conducted hundreds of hours of research and wrote a superb 80-page report. He sent that report, along with written pleas for an inquest, to the coroner and the regional supervising coroner, knowing it was the only way to expose the truth about his daughter's death. He then did the same with his member of provincial Parliament and the Solicitor General. Then, only after sacrificing his family's privacy in going to the media did he hear in December 2008 that an inquest would be held into Sara's death.

For Neil and me, our democratic right to appeal to our elected officials was the only way we could get justice. Without political influence, it would simply not have happened. Yet I stood beside Maryann Murray in the lobby of this assembly upstairs when the former Solicitor General, Monte Kwinter, told her he did not have the power to order an inquest. "Yes, you do," she politely correctly him, "in section 22 of the Coroners Act," the section that is about to be removed. Minister Kwinter chose not to exercise that power, and what happened? The coroner's office, after years, ended Maryann's quest for justice by destroying Martha's heart.

Recommendation number one: We recommend that the amended Coroners Act maintain its democratic roots and keep the ultimate power to order an inquest in the hands of our elected officials by way of a minister of the crown.

Loophole number two: The Ontario Coroners Act prescribes in practice that deaths related to prescription drugs be categorized as "natural." It is critical to note that the vast majority of deaths caused by prescription drugs are contrary, to drug company mythology, not due to prescribing errors, overdoses or patients taking the wrong drug. Neither are they caused by some imaginary unknown allergy that was just discovered. There is nothing natural about a drug killing a patient. Most drug deaths are perfectly predictable and preventable—70%, in fact.

There is no organization in Canada that accurately tracks prescription drug deaths. Part of the reason is that the people who are responsible for prescribing the drugs, our doctors, do not report adverse drug reactions. Health Canada kept note of the 41 drugs that have been pulled off the market for killing and injuring patients since the 1960s, but incredibly did not keep any record of why.

How is it possible that a means of death that kills more Canadians than war, falls, drowning and vehicular accidents together is not even identified in the vast majority of cases? The simple truth is that prescription drug deaths are systematically covered up by those responsible in the pharmaceutical industry and the medical profession in a self-serving curtain of silence, maintained through wilful blindness.

How is that done? Our doctors report less than 1% of adverse drug reactions. Most doctors never report any. This allows the drug companies to print on the labels a tiny fraction of the true number of deaths, to mislead their colleagues. For example, six deaths related to a blockbuster drug taken by a million people would not raise the alarm. If it were 600, the drug would likely be pulled off the market.

Second, of the 1% of drug reactions that are reported, the big pharma companies go to every effort to officially blame those deaths on anything but their drug, often with a total lack of evidence. For example, they simply claim that the deceased patient had some previously unknown condition that chose that exact moment to reveal itself, initiating misplaced suspicion on the patient, or they say the patient is a "poor metabolizer"—there's nothing wrong with the drugs; it's only the patients.

0910

A third reason is the coroner's practice of categorizing prescription drug deaths as "natural." It is impossible to measure the impact this systematic miscategorization has had on the continued carnage prescription drugs wreak on our loved ones. By lowering the curtain of silence over these deaths, our doctors and coroners have paved the way for the pharmaceutical industry to continue corrupt marketing practices and keep risky drugs on the market, long after they've been proven harmful or should have been. This is how Vioxx was allowed to kill as many North Americans as the Vietnam War. Only by identifying drug deaths for what they are can we begin, as a society, to address ways to reduce these deaths.

Our second recommendation is that the committee amend the new bill to demand that coroners create a category for means of death that includes: "related to a medi-

cal treatment including a drug prescribed or otherwise recommended by a medical professional."

Loophole number three: Coroners are not required to do toxicology tests on all patients who die unexpectedly to test for prescription drugs. It's very hit-and-miss.

On May 6, 2007, in Oakville, just 10 blocks from our house, Neil and Rhonda Carlin's daughter Sara died after withdrawing from the GlaxoSmithKline SSRI antidepressant Paxil, in regulatory circumstances very similar to Vanessa. Eight years later, and nothing had changed. Sara was given a drug that was known to cause suicide, especially in youth, where it showed, since 1989, an eight times greater risk of suicide over placebo.

Neither Sara nor her family were given any warning of the long list of dangerous adverse reactions Paxil could cause, including suicide, despite these adverse reactions being right in the official prescribing information. Sara was prescribed Paxil on off-label use, as she was under 18 years old. GlaxoSmithKline had settled out of court with the FDA for $2.5 million regarding concealing information on the safety and efficacy of Paxil and suicide in youth, and were in the midst of a four-year criminal investigation in the UK for the same reason. Sara went home late one Saturday night, put on her makeup and hanged herself.

SSRI antidepressants have been involved in hundreds of suicides, homicides, murders and bizarre acts of violence every year worldwide. In his book Let Them Eat Prozac, world-famous, internationally respected expert Dr. David Healy says that 25,000 people worldwide have committed suicide related to Prozac over the years that would otherwise not have done so.

Both shooters in the Columbine massacre and in almost every school shooting we have been able to find—SSRIs were involved in the incidents. Over 2,600 of these stories are available at the website www.ssristories.com.

When a media story about a shooting or other act of violence without motive says the perpetrator was "treated for depression," that almost always means that the shooter was taking SSRI antidepressants or withdrawing from them. These acts of violence—without motivation—have grown since the widespread use of these drugs has grown.

Recommendation three is that in every unexpected or suspicious death, coroners be required by the act to take blood samples and check what prescription, over-the-counter and so-called street drugs are in the deceased's system, or death related to a disease where timing is suspect, with specific reference to known risks and associations such as acts of violence and SSRI antidepressants.

Loophole number four: A month after Vanessa died, the pharmacist at Joseph Brant Hospital in Burlington sent a report to Health Canada about seven out of nine patients in their cancer ward who died after being given Prepulsid when it was contraindicated. "Contraindicated" means you never, never mix these two, because the benefit will never outweigh the risk. It's a very, very powerful word. All seven patients showed that they had long QT or arrhythmia—the same way Vanessa died and 81 other patients after taking Prepulsid.

I pleaded with the regional coroner, Dr. Karen Acheson, to conduct a thorough investigation. About six months later, she published a two-paragraph report which said that there was no conclusive evidence Prepulsid had caused these deaths. Seven out of nine died the same way Vanessa did—that's "no conclusive evidence." How can that happen?

It's outrageous, first, because, of nine patients, seven died, and the coroner didn't think that was strange enough to continue investigating, and the drug was given when it was contraindicated. But it was possible because the doctors and the drug companies hide behind a clinical standard of proof to prove drug reactions that is ridiculously high, higher than any court in the world—cause and effect. Is there anyone here who doesn't believe cigarettes cause lung cancer? I doubt it. Well, by cause and effect, cigarettes have never been proven to cause lung cancer.

The cause and effect is higher than our criminal standard "beyond a reasonable doubt." To prove a drug killed a patient, you'd have to find a person of the same sex, age and condition, give them the drug, watch them collapse and almost die, withdraw the drug, and then give them the drug again and watch them collapse and almost die again. That's how high the standard is, and that's why the standard is ridiculously high. The standard that should be used in the Coroners Act for a drug death is association. It's another clinical standard and it would help us prevent deaths. So we recommend that the amended act prescribe a reasonable standard of proof for coroners and their juries to prove an adverse drug reaction was the means of death: association.

A loophole in the amended act which we'd like to address calls for the coroner to bring the findings and recommendations of his or her investigation to the attention of the public at his or her discretion. If anything I've told you today surprises you—and I hope it has—I won't have to build a case for shining a light on coroners' findings related to prescription drugs. Publicity about the risks related to prescription drugs will help save lives and should never be optional. We recommend this section be amended to direct coroners to issue public statements to the media when they find that any death—any death—is associated with a prescription drug.

Our conclusion is that the coroner's office has demonstrated over decades that it deems death due to prescription drugs to be perfectly natural. Coroners have been content to cover up both medical errors and harmful drugs, contributing to the fourth leading cause of death in Canada.

Please do not make these recommended changes optional by fixing them later in the regulations or leaving them up to the discretion of coroners. If you do, I don't believe they'll ever be made.

I'd like to finish with a quick quote from my book, Death by Prescription. I'm quoting Dennis T. Mangano, who is the founder, chief scientist and CEO of the

Ischemia Research and Education Foundation. This is from Forbes magazine. He said, "There is no incentive for companies to find problems with safety once a drug is approved. It is just downside risk.... We find out a drug is unsafe when the bodies accumulate."

The Chair (Mr. Lorenzo Berardinetti): Thank you for your presentation. We have almost nine minutes available, so three per party. We'll start with the Liberal Party first.

Mr. Dave Levac: Are we back on rotation from previous times? We normally start with the opposition.

The Chair (Mr. Lorenzo Berardinetti): Did you want to go first, Garfield?

Mr. Garfield Dunlop: Thank you very much. Terence, first of all, let me congratulate you for being here this morning, and on your new career change as well, and on your book.

I know that for all three of you, it took a lot of courage to be here and to bring out the concerns you've had with this legislation. In listening to your presentation and now having an opportunity to read it, I think there are a number of amendments in there that make a lot of sense, that I think would be better left in the bill and not a regulatory change later on.

I think from our perspective as the opposition, when it comes to clause-by-clause, we'd like to work with your organization to help properly word the amendments on this legislation so we can get a healthy debate on the amendments. I'd ask you if you would have any comments on that: working with our caucus research in trying to develop those amendments.

Mr. Terence Young: We'd be pleased to work with your caucus or any caucus. We'd be pleased to work with anyone and share what is basically a front-line experience from families who have lived this, and help you write regulations or the act itself that will help make these changes.

Mr. Garfield Dunlop: When we first started to look at this legislation in first reading, it seemed that the only amendment people were concerned about was the one about the power of the minister to—we're removing that, and we thought that would be an automatic part of the bill to keep in place. Since these hearings have started, though—and this is our second day—we've had a number of fairly significant ideas come forward, and I'm hoping the government members and the government bureaucrats will listen to this, because it has been a long time coming and we want to make sure that we get it right this time

Mr. Terence Young: The opportunity to fix it may not come again for years, so this is our plea: Do it right this time.

The Chair (Mr. Lorenzo Berardinetti): We'll move to the NDP. Mr. Kormos.

Mr. Peter Kormos: That's a full and competent critique of the bill.

I'd ask you to comment on two specific things. We were introduced last week to the word "iatrogenic." I'm still confused, notwithstanding the research that's been done on that. As I understand it, there are certain treatments that carry with them an inherent risk. In other words, you're told, "This is the treatment, but be aware that the treatment may kill you rather than cure you." In surgery alone, there's inherent risk. The best example could be prostate cancer. We're learning that a 70-year-old man who's diagnosed with prostate cancer may well choose not to have surgery.

0920

Can you help me? Because iatrogenic can either mean that there's an inherent risk or that there's, in effect, malpractice; and I think they're two separate things. Remember, we talked about that last week. I'm still troubled by the one category.

The other one is—and this is not provincial, I suspect—I'm troubled by the glossy magazine and television advertising by pharmaceutical companies of mostly drugs that are related to comfort issues, whether it's emotional comfort, body comfort—

Mr. Terence Young: Conditions.

Mr. Peter Kormos: Yes—rather than actual diseases, that encourage people to self-diagnose and to go to their doctor and demand of busy doctors with rushed practices that they get prescribed these drugs. Could I get a comment on both of those things, please?

Mr. Terence Young: I will briefly, and then perhaps you'd like to comment, Maryann.

We are opposed to the expansion of direct-to-consumer advertising. It leads to inappropriate use of prescription drugs. They only advertise the drugs they make the big money on and the drugs that are relatively new, they don't advertise the best drug for the condition, and they're bypassing our doctors. They're designed to bypass doctors. The TV ads, for example, of people singing and dancing in the street for Viagra—it's all a big joke, but hundreds of men have died after taking Viagra. A number of men have gone blind after taking Viagra because either they were taking nitroglycerine or they had low blood pressure at the same time. So it can be a dangerous drug.

The point is, all drugs cause adverse reactions—all drugs—and the only difference between a drug and a poison is dosage, so it's flippant, misleading and inappropriate to advertise drugs on television. It's against the law in Canada. They do it anyway with those ads that say, "Ask your doctor," and that's after they've already got you very upset in the middle of your favourite show, showing some poor guy falling dead at a family picnic in an ad for Lipitor. Those ads, we believe, are illegal. They sort of fit in a grey area in the legislation and we'd like to see them stopped.

Iatrogenic error is when a doctor takes an action and it harms the patient. It's not necessarily malpractice, but every doctor, when they graduate from medical school, swears to do no harm, and that's an issue of caution. They swear to be cautious in providing care that they don't take any action—no doctor ever wants to do that. It must be heartbreaking for doctors. Unfortunately, that's what leads to a lot of the fact that doctors don't report

adverse drug reactions—only 1% get reported—they feel so terrible about it. Sometimes they're not sure that their action, something they did, caused a drug reaction; and sometimes they're worried about getting sued, to be frank about it. We're not down on doctors. I have a brother who's a wonderful surgeon in Hamilton, Ontario, but systematically, these things are getting covered up because they have been traditionally and because the legislation doesn't let it be exposed.

Do you want to comment on iatrogenic—

Ms. Maryann Murray: I agree that an iatrogenic death just means that it's a death that was caused by the treatment; it doesn't necessarily mean someone was negligent. You can think that it's the best choice and have a very unfortunate outcome. But we're all making the point that those unfortunate outcomes need to be recorded as such and that we need to see whether maybe a lot of people are getting the same unfortunate outcome. It's not necessarily negligence at all. I think that most people are not negligent but that all of us, being human, make mistakes; and I think it's just a term that we use for what would turn out to be a medical error, because you wouldn't foresee hurting someone in the first place.

Mr. Peter Kormos: Thank you kindly.

The Chair (Mr. Lorenzo Berardinetti): Mr. Levac.

Mr. Dave Levac: First, let me thank you for sharing not only your presentation, but your stories, and my obvious support and sympathies for what you've had to go through. The very serious nature of this presentation seems to me to be put in perspective in terms of what you're doing, which is evidence-based. It appears to be evidence-based and it's asking for the cloak to be removed from that. I appreciate that comment and concern, and obviously you know how the committee works: There are staff and individuals here who are hearing this clearly, things to investigate and review.

I was very pleased to hear your answer to the opposition question, that working with everybody is the most appropriate way to do this.

Mr. Terence Young: It's a non-partisan issue.

Mr. Dave Levac: Absolutely, and I'm sure that everyone understands that. I'll make the undertaking to make sure that the staff are made aware of contacts with you, in order for us to work with you as well to ensure that the concerns that you raise are dealt with.

I can't make a commitment as to, "Yes, I'm going to throw an amendment in right away." But we need to have an honest discussion of the issues that you bring forth, because you represent a larger group of people, and it's growing. We cannot deny that reality. I will do what I can and undertake to make sure that the minister has been made aware of the concerns that you're raising for us.

I have one quick question, and then I'll turn it over to my colleague. Who determines the "suspicious death" component? It's the coroner, correct?

Mr. Terence Young: Yes, from my understanding.

Mr. Dave Levac: Yes, from my understanding, it's the coroner. So the idea would be to ensure that the classification of a suspicious death then ties in to what you're asking for: that once it's declared, then you have to do certain things in order to eliminate it from being a prescription drug death.

Mr. Terence Young: We read about bizarre acts of violence all the time, the group of people I work with on the Internet across North America. For instance, a woman jumped off a bridge on the 401, I think it was about two years ago, with her infant: The first thing we look for in the newspaper report is "drug treated for depression" or if a drug was involved.

I spoke with Kimveer Gill's father—he's the one who shot up Dawson College in Montreal—and asked him, and his father said, "Oh, that was long ago." So I couldn't get a clear answer. But just because someone is no longer on those drugs, that doesn't mean anything, because it takes weeks and sometimes months to totally withdraw from those drugs. They affect your brain in a similar way to LSD, in fact.

Mr. Dave Levac: Okay, thank you. Jeff? That's good for me, Mr. Chair.

Mr. Jeff Leal: Mr. Young, I want to thank you and your other two presenters today for sharing your profound human side and the tragedy of this issue. I know you've done extensive research in this area. Is there a fundamental weakness in the way the federal Food and Drug Administration in the United States tests drugs, and indeed here at Health Canada? As a consumer, I take a high blood pressure medication, and I assume my doctor—a fine family physician in Peterborough—prescribes that to me with a sense, and I have confidence when I take that medicine, of the potential adverse effects of that. Is there a fundamental flaw in the way we do our testing in the United States and Canada? I understand the big drug lobbies—we see them all the time on CNN promoting a wide variety of products.

Mr. Terence Young: The FDA and Health Canada do not test drugs. The labs were closed in Canada in 1997. Drug companies test their own drugs. When a drug is approved, the new drug application arrives in one or two trucks full of boxes, and some doctor-drug reviewer has the unenviable task of going through those boxes and trying to decide what's right and what's wrong and if this drug is safe. They start to get phone calls from above and pressure from the pharmaceutical companies to approve the drug faster. So they have to go through all this stuff and make a decision. Sometimes the decision is wrong, but sometimes the decision can be right based on the evidence, but a danger of a drug doesn't show up until it's taken by thousands of people, because it might kill only one out of 10,000 people, or it might only destroy the liver of one in 10,000 people. Well, if a million people take the drug, there are 100 people who need a new liver.

The process has to be more cautious. What Health Canada and the FDA have been doing in recent years is, instead of being more cautious, they're approving drugs even faster. It's one of only two positions in the government where you don't want people to do things faster. You don't want people standing over air traffic con-

trollers and saying, "Hurry up. Get those planes in." And you don't want people standing over drug reviewers and saying, "Hurry up. Where's our drug?"

The other side of that, of course, is that 97% of new drugs on the market offer nothing new to patients, no new therapy; they just do what other drugs do. Only 3% are considered breakthrough or new therapy in any way. Now, if they wanted to rush those drugs with an extra team of doctors reviewing them and looking at them, and the benefit is outweighing the risk, we would have no objection. But always with medical care, the benefit has to outweigh the risk. The patient has a right to make an informed choice, and patients aren't getting warnings. They're not being told; neither are their families. They're not making informed choices.

Mr. Jeff Leal: Mr. Young, if I could just follow up quickly, the reason, I take it, the labs were closed in the States and Canada was to speed up the review in not having the extra peer review of a particular drug—is that right?

Mr. Terence Young: Well, they started with the AIDS drugs in the 1990s. They said, "We've got to get these drugs on the market faster." Then, once they got that process—because these drugs save lives, and the benefit does outweigh the risk fairly easily if you're going to die—they started to expand it to other drugs as well. Since 1997, 12 major drugs have been taken off the market in the United States, and 11 in Canada, for killing and injuring patients. Prepulsid is just one of them. Obviously those drugs shouldn't have been approved, and if they were approved, they shouldn't have been taken by so many people so quickly, but it's the promotions and the direct-to-consumer advertising, and the drug reps are in our doctors' offices, frankly. I have two chapters in my book about the inappropriate relationships—the golf games, the dinners, the trips to the Bahamas, the trips to Egypt—and the doctors have debts of gratitude. How can a doctor pay a debt of gratitude to a drug rep? They put their drugs in our bloodstreams.

0930

Mr. Jeff Leal: Thank you so much for lifting this veil on this particular issue. I truly appreciate that.

Mr. Terence Young: Thank you.

The Chair (Mr. Lorenzo Berardinetti): Mr. Kormos.

Mr. Peter Kormos: The Chair might inquire as to where on April 14 Mr. Young's book launch is here in Toronto and at what time, and who the publisher is.

Mr. Terence Young: I'm going to ask one of the people to send out an e-mail. We're going to do a book launch at Massey College, so if anybody wants to come, just walk over after work.

Mr. Peter Kormos: People read this Hansard, though. Give us the date, time—

Mr. Terence Young: We're working on April 14 at 6 o'clock at Massey College.

Mr. Peter Kormos: And the publisher?

Mr. Terence Young: The publisher is Key Porter, which I'm so grateful to.

The Chair (Mr. Lorenzo Berardinetti): If you forward something to the clerk, we'll endeavour to get it to every member of the—

Mr. Peter Kormos: People read the Hansard of committees, and—

Mr. Terence Young: Thank you.

The Chair (Mr. Lorenzo Berardinetti): All right. Thank you very much, Mr. Young, and all, for coming this morning, and for your very informative presentation.

We're running a few minutes behind.

CHI-KUN SHI

The Chair (Mr. Lorenzo Berardinetti): Our next presenters are Ms. Chi-Kun Shi and Jenny Chu. Good morning, and welcome.

Ms. Chi-Kun Shi: Good morning.

Mrs. Jenny Chu: Good morning.

The Chair (Mr. Lorenzo Berardinetti): You have 20 minutes to make your presentation. Any time you don't use will be used by the committee members to ask questions.

Ms. Chi-Kun Shi: Thank you. My name is Chi-Kun Shi. I am a lawyer. I am here on behalf of Steven Chau, a patient with schizophrenia. With me is Mrs. Jenny Chu, his sister.

First of all, thank you all for hearing us today. I know it's a very busy day at the Legislature.

We are here to present Mr. Chau's case to illustrate the importance of section 22 of the Coroners Act in safeguarding public health. We join Mr. Young's call to maintain section 22 in the Coroners Act. Section 22 gives the minister the discretion to direct the coroner to hold an inquest and simplifies the procedure for doing so.

Mr. Chau is currently held in the Whitby Mental Health Centre. He has been there since he was found not criminally responsible for the murder of his wife, Shao-Fang Liang, his three-year-old daughter, Vivian, and five-month-old son, Ivan.

The background of this case and the selection of documents related to it are in the brief before you. It's the one with all the tabs.

On the morning of February 9, 2006, Steven tried to get a ride to his doctor's office to seek help for his schizophrenia. By the time his friend arrived to give him the ride, he had locked the door and gone into a full-blown psychosis, which caused him to kill his wife, Shao-Fang, his daughter, Vivian, and his son, Ivan, using a meat cleaver.

Steven's schizophrenic conditions had been held under control for 18 years by the monthly injection of a low dosage of a medicine called Piportil. It was administered at his family doctor's office due to a shortage of psychiatrists. He missed his January 2006 injection. He killed his family 12 days later.

At the preliminary inquiry into the murder charges, both the family doctor and the psychiatrist were extensively cross-examined as to any safeguards that may have existed to ensure that patients such as Steven take their medicine as required.

You will find excerpts from such testimony under tabs 2 and 4 of the brief if you'd like to read them. Both doctors also gave written statements on this issue, and they are contained in tabs 6 and 7. I would like to read from it to show what seems to be the current situation on this issue.

First of all, under tab 6 is the statement of the family doctor, Dr. Edmund Lo. It stated: "It is up to the family to remind the patient to come in and take his medicine. We simply can't remind all of our patients. Mr. Steven Chau got an injection on December 28, 2005, of Piportil L4, 25 mgs. He did not have an appointment thereafter. We don't schedule a next appointment. It is up to him to schedule it. He should have had another one at the end of January 2006."

Then his psychiatrist, whose statement is in tab 7, on the third page, said that Mr. Chau was supposed to be on Piportil. He would have been in there to get the regular dosage, and he said, "It is the responsibility of the patient and family to make sure they come."

Steven's care had been downloaded onto his family physician, whose experience with schizophrenics was very limited. Specifically, if you were to go to the footnote if you would like to read it—I won't turn to it. He testified at the preliminary inquiry that he's only ever treated five schizophrenics. On the other hand, Steven's time with his psychiatrist during 12 years was about 140 minutes in total. This testimony, the psychiatrist's transcript, can also be found in tab 4.

For about six months before the tragedy, Steven had displayed clear symptoms of breakthrough of his schizophrenia. According to the agreed statement of facts accepted by the criminal court, which is in tab 3, these symptoms included Steven's belief that his children were the devil and his irrational behaviour of attempting to excise the household of evil spirits, such as boiling water continuously for 24 hours and throwing out his children's toys. Despite all of this, his family doctor did not increase his dosage, nor did the doctor heed Mrs. Chu's warnings about his ominous conduct and her plea to commit Steven. The doctor denies to this day that the warnings occurred.

After Steven was found not criminally responsible in 2008, on November 18, 2008, he requested that the coroner hold an inquest into his family's deaths. On the same day the request was submitted, Mrs. Christine Elliott, a member of this committee, asked Minister Bartolucci to exercise his discretion under section 22 of the Coroners Act and direct an inquest. Minister Bartolucci replied that there is a process in place that requires him to allow the request to be handled by the local coroner, then the regional coroner and finally the chief coroner. As a result, the request remains outstanding as of today, more than four months later, waiting to be examined by the pediatric death review committee and the deaths-under-five committee at the coroner's office.

Contrary to Minister Bartolucci's position, the courts have in fact interpreted the minister's discretion under section 22 as one which provides, "overriding authority ... to order an inquest at any time regardless of what has gone on before" in the coroner's office. I have enclosed a copy of the case under tab 11. The case was decided in Superior Court, affirmed at the Court of Appeal, and application for leave to appeal to the Supreme Court of Canada was denied.

It is our submission that section 22 could and should be involved in cases such as this to launch an inquest. The proposed abolition of section 22 will eliminate this very effective tool. This tragedy has received extensive media coverage in both the Chinese and other media. In the Chinese media it has received blanket coverage, with many reporting Steven's request for an inquest as front-page news. Our announcement of the request, which we did at a press conference at the Queen's Park press gallery, was very well attended. I have enclosed a chart summarizing a selection of media coverage for illustrative purposes in tab 9. It was not possible to include all the coverage.

This tragedy raises obvious and disturbing issues of public safety. Steven was not resisting medication: He fell off the wagon, and the system did not catch him. At his last moment of lucidity, he called his friend Sam to drive him to the doctor, but by the time Sam arrived it was too late, and his family bore the brunt of the catastrophe that ensued.

Steven did cry out for help. So did his family. Mrs. Chu was very alarmed by his symptoms and tried desperately to get him committed. The cries were not heard, and the system failed. I respectfully submit that this is an obvious case for an inquest. The pre-eminent forensic psychiatrist Dr. Hy Bloom, who examined Steven, said it best: "The Chau case is just one example of many where one or more shortcomings in patient care, communication and resources have resulted in a tragedy." Careful retrospective analysis often yields valuable information about how not to make the same mistake. The exercise is worthwhile when the stakes are the well-being of patients and families and the safety of the community. Dr. Bloom's statement can be found in tab 10 of the brief.

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A minister's discretion to direct an inquest under section 22 of the Coroners Act removes the waiting period dictated by the coroner's office workload and allows public safety concerns to be addressed without delay. It should remain available in order to address issues of public safety promptly. I submit that we do not require another tragedy such as the Chau family's case to realize that when public safety is concerned, time is always of the essence. Furthermore, communities such as the Chinese Canadians have needs and barriers that are unique to them, such as language and stigma. For these communities, section 22 of the Coroners Act provides a simple and direct means to access the system.

Finally, I would like to finish my submission by outlining the questions that a Chau inquest could address:

(1) How can the existing system be improved to better receive and respond to mental health patients' cries for help, and on a more timely basis?

(2) How can the existing system be improved so as to assist and ensure that mental health patients who rely on

their medication to control potentially violent tendencies do not miss their regular dosages?

(3) If and when the dosages cannot be administered on a timely basis, what safeguards should be in place to protect the public from dangerous psychosis?

(4) How can the existing system be improved so that mental health patients receive care from qualified practitioners attuned to systems that demand intervention not only to address the patient's health care but also to protect the patient's immediate surrounding family and community from harm?

(5) How can the existing system be improved so that children who are in the regular care, custody or presence of mental health patients can be better protected, as they are obviously unable to protect themselves, nor are they able to judge as to when they are in danger?

Members of the committee, Steven's request for an inquest is very unusual. It's very unusual for a killer to ask for an inquest. It is a cry for help. It is too late for his wife and children—and if you'd like to have a look at them, I have included their photos under tab 8—but he is asking for help for all the other Shao Fangs, Vivians and Ivans who are out there. The minister can respond to the request now by invoking section 22 of the Coroners Act and not abolishing it. Thank you.

The Chair (Mr. Lorenzo Berardinetti): Thank you very much. We have about eight minutes, so roughly two and a half minutes or so, starting with the NDP.

Mr. Peter Kormos: Thank you very much. I believe all of us are familiar with this matter because you were here at Queen's Park some short time ago making a plea for the Solicitor General to invoke section 22.

Thank you very much for a very thorough brief. As you were talking, I was trying very hard, and I believe I did hear what you said as well as going through the brief and reading or at least scanning most of the material. There's really nothing more to add than the fact that we share your concern about the repeal of section 22.

Ms. Chi-Kun Shi: Thank you.

Mr. Peter Kormos: The mere fact that it's not used often isn't a reason to repeal it. In fact, it's a demonstration that Solicitors General don't use it willy-nilly. The fact that it's not used often is an argument to keep it because it demonstrates that people have had to meet a very high standard before the Solicitor General would effectively overrule a coroner and then chief coroner.

I don't understand the logic of it. I suppose it's one of those things where if politicians want to avoid the responsibilities of their office, they do things like repeal section 22. You see, that way it becomes much easier to be a Solicitor General. You just cruise through—you can do it standing on your head, huh, Chair?—because you don't have to make these decisions anymore. I find that a regrettable course in political responsibility.

Thank you for coming in here. I hope everybody reads the brief, because when you read it in its totality, it's even more compelling. Thank you.

Ms. Chi-Kun Shi: Thank you, Mr. Kormos. If I may add, the community concern about this case has never abated. In fact, if I choose to go, I have been invited to not one but two radio interviews next week to talk about any progress, specifically on the topic, "Is anything being done about this?"

The Chair (Mr. Lorenzo Berardinetti): We'll move on to the Liberals.

Mr. Dave Levac: To Jenny, my apologies and sympathies to the family and to the community. As Mr. Kormos pointed out, I am aware because of the notoriety of the case, so my obvious first response is my sympathies to the entire family and the community for what they've had to go through.

I appreciate deeply the depth of the presentation, and I, too, was looking at it. I don't subscribe to the characterization that Mr. Kormos made of any one politician in this place, regardless of what party they belong to, who would ever try to skirt any kind of responsibility. It's an evaluation that's being done in the proposed updating—as a result of Dr. Smith's actions—of a very old act to try to improve the circumstances.

The comments are heard and the comments are recorded. The staff, the minister, myself and our committee are listening carefully to all the deputations, and those inputs will be used to make some final decisions on how the bill will look. I hope you don't go away with the characterization that any one minister is trying to abdicate any of their responsibility whatsoever. It's just a different way of looking at things, and I happen to subscribe to a different opinion, not necessarily one that makes politicians look bad. I'm trying to hear as much information as I possibly can and share that with the minister and share it with staff. I deeply appreciate your presentation. It will be listened to, it has been heard and we'll make some deliberations along with this committee and, finally, the minister's office on how the final bill will look.

I appreciate very much what you've gone through.

The Chair (Mr. Lorenzo Berardinetti): We'll go to the Conservatives.

Mr. Garfield Dunlop: I just want to say thank you for coming. I want to apologize on behalf of my colleague Christine Elliott. She has been held up in Whitby. She's called her office once this morning already. She would like to follow up more closely with this presentation as well because she asked the question in the House to Mr. Bartolucci.

We hear you loud and clear and we'll look forward to working with the government to make sure the proper recommendations are put through, including the one on section 22, of course. I think that's an automatic—they'll withdraw that.

Ms. Chi-Kun Shi: Thank you.

The Chair (Mr. Lorenzo Berardinetti): Thank you once again for your presentation and for coming this morning.

ADVOCACY CENTRE FOR THE ELDERLY

The Chair (Mr. Lorenzo Berardinetti): Our next deputation scheduled is the Advocacy Centre for the

Elderly, Jane Meadus. While you're settling in, the procedure is basically that you have 20 minutes to present. Any time that's not used during that 20 minutes will be time that the members of the committee can ask questions. So welcome, good morning, and feel free to proceed once you've identified yourselves.

Ms. Jane Meadus: Good morning. Thank you, Mr. Chair and members of the committee. My name is Jane Meadus and I'm a lawyer at the Advocacy Centre for the Elderly. With me this morning is Lisa Romano. She's also a lawyer at the centre. Together, we prepared the written document that you should have before you this morning. I'll be doing the oral submission today.

For those of you who aren't familiar with our legal clinic, we are a specialty clinic which provides services to low-income seniors in Ontario. We provide services in the law with respect to issues of age. My expertise is in the area of long-term care, and that's where most of what we'll be talking about today will come from.

First, I would like to endorse two written submissions that were presented, one by Marshall Swadron on behalf of the Mental Health Legal Committee, and Suzan Fraser, a barrister and solicitor who was one of the counsel at Goudge. We wanted to endorse those.

I also think that our comments will come nicely after Mr. Young's. We share a lot of the same concerns that he does. It's interesting: I have just finished reading a book called Our Daily Meds. Some people had expressed some interest in some material on this issue. That's an American book that talks about the drug industry, which I suspect will be a good counterpart to Mr. Young's book. I just mention that to you.

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The mission statement of the coroner's office says:

"We speak for the dead to protect the living.

"The Office of the Chief Coroner for Ontario serves the living through high-quality death investigations and inquests to ensure that no death will be overlooked, concealed or ignored. The findings are used to generate recommendations to help improve public safety and prevent deaths in similar circumstances."

We, obviously, thoroughly support that; we just don't feel that it is happening in all cases. We certainly come from the area of long-term care. Our experience is that we have been involved in many inquests, including the Meadowcroft inquest into a retirement home where a number of people were killed in a fire; the Kidnie inquest, where an elderly woman was involved in a car accident that killed another woman. I represented a group at the John Wilson inquest, who was a gentleman who set himself on fire in a chair in a long-term-care home. Finally, I represented Concerned Friends at what is known colloquially as the Casa Verde inquest, which was about the gentleman who murdered his two roommates within seven hours of admission to a long-term-care home. These were very important inquests. They brought a lot of very good information to light about the systems. What they didn't do was show the day-to-day problems, such as the issues of overmedication and adverse effects. This is something that is not looked at and is missing in our coroner's system.

When we looked at the Goudge report, it was a totally different system than what we deal with with seniors. The Goudge report was talking about a problem with forensic pathology and Dr. Smith's actions. Our clients don't get that far. The coroner comes in, if we're lucky, may or may not see the body, and generally assumes that the death was one of some kind of natural cause—heart attack etc. So even though there's a lot of research out there that talks about the thousands of deaths that occur because of adverse effects of medication etc., they're not being looked at because no one takes the time to actually research that.

What has happened in the past in long-term care is that there was a system in place, up until fairly recently, where a long-term-care home would keep a list of the deaths in that home. They would have a list in their office and then the coroner would be called on what they called the "threshold death," which was the 10th death, and then they would look at those. This was so highly misinterpreted that even if someone had something like a fall or there was a homicide, things like that, the coroner wasn't necessarily called because they said, "It's not the 10th death; we don't have to call." They weren't calling in, the normal course, where there were homicides; in fact, at the Casa Verde inquest, one of the things that we found out was that there had been a number of homicides that had never been reported to the coroner's office. The coroner would just come out, look at the sheets and sort of check off on them. They're not doing the kind of investigations that we think are necessary in the long-term-care homes.

There are 600 homes in Ontario and 75,000 residents, which of course does lead to a huge number of deaths, and most of those would be of natural-type causes. However, we don't feel that at the present time there's enough investigation or enough questions that are being asked. They're not asking what kind of medications people are on, what precipitated things. We have a lot of deaths from poor restraint use, so people are getting strangled on restraints, people are getting legs caught in bedrails where they would get their legs, hips broken, and they might go to the hospital. They may not be reported to the coroner. We actually have a lot of issues in the system and we feel that one of the things that should happen is that there should be a better definition of what a coroner is, what his qualifications are, in the legislation. They should have some kind of investigative requirements. So what we see from Goudge is great. We think it's great and it's come into Bill 115 quite nicely, but our clients don't even get to the door, and it's a problem.

Very often, when we get calls at our office, it is from a family whose family member has either died under circumstances which are suspicious or unsettling, let's say, or something has happened and they know that the family member is going to die. We have to tell them to call the coroner because it will not happen in the normal course, even though it should because it's a death that

was unexpected or from a fall or something. So we really feel that this is important.

Another issue that we would like to bring to this committee's attention is the use of the review committees. As you may know, there's a pediatric review committee. There's also the geriatric and long-term-care committee, and that doesn't appear anywhere in legislation. We would like an amendment to the regulation portion so that this can be put into the regulations at a later date: which committees there have to be; how often they have to report; who should be on the committees—and that's really important, especially in the area of geriatrics, because a lot of the issues do deal with long-term-care homes and placement issues about discharge from hospital. The committees, at the present time, are made up of all medical personnel, and there are problems because they sometimes don't get the systems right or the law right.

A case in point is one report that appeared in the 2000 report. This was a woman who had a mental health issue as well as physical issues. She was admitted into a long-term-care home and was under the decision-making authority of the Public Guardian and Trustee. The home asked them to sign what they call a "do not resuscitate" order. The PGT did not do that because substitute decision-makers don't have that kind of authority. This woman didn't have any kind of illness that one would think that she would need resuscitation for. Eventually what happened was, the woman fell in her wheelchair, was in the restraint, and something happened—oxygen was cut off—and she died. The staff did not provide CPR because the home had a no-CPR policy unless there was a specific order. So they weren't using their medical knowledge to decide when a person should be resuscitated. Unfortunately, what came out of that was they said the PGT should do a better job of making these kinds of reports, instead of saying, "Hey, look, these people in the homes have their medical personnel. They should be making their own decisions." When you come upon someone and they're having problems, they've just gone into cardiac arrest, you have to sometimes use your own medical decision-making to decide when to give CPR. We have machines in arenas, in GO stations, in all sorts of places now, yet in a long-term-care home, you're very unlikely to get CPR unless someone has specifically requested it, and they don't want to make their own decisions. So there are a lot of issues with respect to that.

You may want to look at some of those geriatric review committee reports, because I think they're quite interesting. The other thing is that they're not very widely read. The same types of information are in them every year. I read the same reports about the same kinds of deaths every year. They're very useful to me. I've actually had cases where I've taken a report and sent it to a hospital and said, "You have to look at this because this is a problem," and a person has been treated because of that. I'm certainly not a doctor, but it's things like fecal impaction that are constantly not treated properly, restraint issues etc.

I'm going to stop there in case you have some questions. Thank you.

The Chair (Mr. Lorenzo Berardinetti): We have about seven minutes or so for questions, so a couple of minutes each. This time around, we'll start with the Liberal Party and Mr. Levac.

Mr. Dave Levac: Thanks very much for your presentation. Obviously, your advocacy for seniors is appreciated. It's obvious, with your deputation, that you've been involved in a large-detail factor in some of these unfortunate deaths, so I appreciate the work that you're doing.

Ms. Jane Meadus: Thank you.

Mr. Dave Levac: If I've got this right—and I'll do a little synopsis of this—you're hoping that committee structure is found within the regulatory body of the bill; if the bill is passed, then there's a regulatory regime to create and define and tighten up the committee work of various sections of that committee. There's the prescription drug issue that you think needs to be captured in the body of the bill, similar to what Mr. Young presented earlier, and that because of the nature of the Goudge report and the fact that you think the scope is narrow in terms of how the bill is responding, you would want to see its scope broadened to capture other areas that you've identified as things that are not covered in the bill. So are those three things the key function of what you're asking us to do?

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Ms. Jane Meadus: Yes.

Mr. Dave Levac: I appreciate that, and the words are there. We'll work with the staff to discuss this in-depth, and I'm sure the committee, from all sides, will try to implement those thoughts. I appreciate what you've done.

The Chair (Mr. Lorenzo Berardinetti): We'll move on to Mr. Dunlop.

Mr. Garfield Dunlop: Thank you for your presentation today. I was interested in the part of your presentation on the long-term-care homes.

Maybe you can't share this, but I'm wondering if your organization has actually worked with the long-term-care-bed association, the people who run those homes, and if you might tell us if you've had that conversation or what kind of an impact you've had with them.

Ms. Jane Meadus: We have a lot of interaction with long-term-care homes—the OLTCA, the Ontario Long Term Care Association, as well as ONNHA, which deals with the homes for the aged, and the non-profit groups—not necessarily specifically around this topic, although certainly during inquests, we do have conversations about some of this stuff.

I think one of our areas of most concern is around the prescription drugs and the use of that. It is very difficult. Yesterday I was talking to a client whose parent was in a long-term-care home, who indicated she'd been concerned because her mother was being prescribed one of these anti-psychotics, which comes with black box warnings saying it's not to be used in the elderly and it causes heart attacks, and the staff member sort of assured

her that no, this was perfectly safe and that 60% of the residents in that home were on this medication.

It can be very difficult to deal with it sometimes, because they have different perspectives on it. They see it as being beneficial, and we just don't. So we certainly have conversations; we don't necessarily agree.

Mr. Garfield Dunlop: If I may just quickly say, we've been dealing a lot with long-term-care homes in our ridings. They're looking for more funding, they feel they're severely underfunded, and this may be another reason that we can go back to them with and say this is another reason for the government to increase funding so as to provide proper nursing care etc. that they don't have right now.

Ms. Jane Meadus: I'd be for anything that increased funding.

The Chair (Mr. Lorenzo Berardinetti): We'll go on to Mr. Kormos.

Mr. Peter Kormos: I've managed to read most of your brief at the same time while listening carefully to you. There's a pattern, in just the couple of days that we've been allowed to sit, because we're hearing the unfortunate stories, right?

Ms. Jane Meadus: Yes.

Mr. Peter Kormos: We're not hearing the good-news stories, and that's to be expected, but there's a pattern and I don't know how to articulate it. There's something about the unspoken evidence about the demeanour or attitude or perspective of coroners; something's going on. Are they treating these things in a sausage factory manner, or are they treating them overly casually, or are they not interested in taking on the extra work? What's going on in the unfortunate cases?

Ms. Jane Meadus: I'm not sure exactly what's happening. I've dealt with some of the coroners. You've got your different levels of coroners: You've got your regionals, you've got the guys who have been around for a long time, and then you've got the people who come out on the day-to-day basis, they get the phone call and they come out.

Some of them seem to be very excited about things and some don't. I think that there does tend to be, certainly in the area of long-term care, that, well, it's only an old person and they were dying anyway. That seems to be some of what the problem is. I think it's the very opposite of what we heard at Goudge where Dr. Smith said, "Think dirty." I think they think clean in the area of long-term care and people who are seniors.

Mr. Peter Kormos: Interesting, and your perspective on seniors—of course, there's a whole group or movement that treats seniors' care on a cost-benefit basis.

Ms. Jane Meadus: Absolutely.

Mr. Peter Kormos: And that argues that when we have limited resources, seniors should be at the end of the line because, after all, their life expectancy based on actuarial tables is only that much. That's seen by some people as an enlightened perspective. I trust you don't agree.

Ms. Jane Meadus: I don't agree. I think one of the interesting points is that with seniors, the coroner's office is often the only place that you can go to get any kind of resolution, because lawsuits in the area of seniors are something that, if you go to court, any lawyer will tell you that there's no money in it and it's going to cost too much. This is why it's so important to get the coroner's office really looking at some of these deaths, because it's the only game in town sometimes.

Mr. Peter Kormos: Thank you kindly. I wish we had more time.

Ms. Jane Meadus: Thank you.

The Chair (Mr. Lorenzo Berardinetti): Thank you for coming out today and for your presentation.

ALEXANDER FRANKLIN

The Chair (Mr. Lorenzo Berardinetti): We'll move on to our next deputation: The Worshipful Society of Apothecaries of London, Dr. Alexander Franklin. For members of the committee, there is an e-mail at the bottom of your package for today which contains some of the information, if I'm not mistaken.

Dr. Alexander Franklin: Thanks to Ms. Sourial.

The Chair (Mr. Lorenzo Berardinetti): Good morning and welcome.

Dr. Alexander Franklin: Chairman, members of the committee: Canada lacks a postgraduate diploma—

The Chair (Mr. Lorenzo Berardinetti): Sorry to interrupt. I know I've already mentioned your name, but just for—

Dr. Alexander Franklin: The name is Franklin.

The Chair (Mr. Lorenzo Berardinetti): All right. Thank you.

Dr. Alexander Franklin: Canada lacks a postgraduate diploma in forensic medicine. This is significant, as coroners are often primary practitioners. The Worshipful Society of Apothecaries of London, whose charter was granted by King James I in 1617, offers amongst its 10 postgraduate diplomas the following, in historical order:

—1962: diploma in medical jurisprudence, followed in 1993 by the mastership;

—1998: diploma in forensic medical sciences;

—2002: diploma in forensic human identification.

For the clinical diploma in medical jurisprudence, there are 10 examiners. All are GPs with special interest, which is a designation recognized by the United Kingdom's National Health Service. Five examiners also have the legal qualifications of master of law. For the pathology diploma in medical jurisprudence, there are also 10 examiners, of which four are full professors, not associate or assistant. For the odontology diploma in medical jurisprudence, there are three dental examiners. For the diploma in forensic medicine, there are 12 examiners, including two full professors; six are members or fellows of the Royal College of Pathologists. Others are chemists, microbiologists or GPs with multiple diplomas.

It would seem reasonable for Ontario coroners to have at least one of these diplomas, which would require staying in London for a year's education at a cost of, I estimate, about $150,000, all included. The ideal would

be a coroner with all three diplomas, which could be achieved over time.

As Ms. Sourial has so kindly provided, the apothecaries' website is at www.apothecaries.org. For the record, my background is liveryman of the apothecaries since 1965; MBBS, London; diploma of physical medicine and rheumatology in the UK; and Toronto diplomas in public health and industrial medicine with qualifications in Canada and the USA.

If any communication about this is required, I've put down my e-mail, scandiamed@aol.com.

Thank you very much.

The Chair (Mr. Lorenzo Berardinetti): Thank you. We're supposed to start with the PCs, but we'll start with the NDP.

Mr. Peter Kormos: Dr. Franklin, needless to say, I've been anxiously waiting to hear about the Worshipful Society of Apothecaries of London since I read today's agenda.

This is an interesting point, and perhaps research would help us: Are there jurisdictions which require certain academic qualifications for people to perform this speciality of—how would you describe the specialty of being a coroner? Is it a pathologist, forensic—describe the scope of the coroner's role above and beyond a general practitioner.

Dr. Alexander Franklin: It's a very wide field, Mr. Kormos, as your past activity has shown to great advantage to the medical profession in Ontario. We all thank you very much.

It is really an application of law to medicine and medicine to law. It is, I would say, by its division into the clinical, the pathology, the dental science, how you apply law to medicine in the interest of the state and the person.

Mr. Peter Kormos: Again, I wonder if research could help us with an overview, not an intensive, but just sort of a demonstration of what different jurisdictions require of people before they are coroners, especially at that front-line level—the local or the regional court—because that's the gateway.

Dr. Alexander Franklin: Yes.

Mr. Peter Kormos: Thank you kindly. You've raised an important issue for us.

The Chair (Mr. Lorenzo Berardinetti): Thank you, and I'll move to the Liberals. Mr. Levac?

Mr. Dave Levac: Thank you, Dr. Franklin. I appreciate you bringing to our attention the depth the apothecaries of London provide in terms of this particular scope of practice. As you've pointed out, it is broad and wide-ranging, but so is medical practice itself; it's even broader and wider.

I want to pick up on what Mr. Kormos was questioning in terms of research. I would like to broaden that a little bit as well to include courses or available upgrading, which I'm assuming—and I shouldn't do that—might be part of what you provide as a service as well; that in London not only do you get a diploma but you get upgrading and in-service or professional development? Or is that too broad an expectation?

Dr. Alexander Franklin: I don't believe the apothecaries offer that. They just offer the diplomas. But one of the great advantages in London of the numerous medical societies—unfortunately, in one of the great tragedies of Canadian medicine, the Toronto Academy of Medicine failed financially in the late 1980s. For example, in London it's really a non-stop performance of continual medical education. The Royal Society of Medicine has conferences and meetings going on six days a week, from early morning till late at night. There's the Medical Society of London, which I remember, and other societies. So if one looks at what's going on any day in London, it is incredible the amount of free—they're all free—lectures. Now, the Royal Society of Medicine, I should qualify that, is not free; for that you have to be a member. But the Royal Postgraduate Medical School and other places have continuous free lectures, which does not happen here in Toronto, where usually there is a fee.

Mr. Dave Levac: Thank you, Dr. Franklin. And a question too, Mr. Kormos, if you don't mind me adding that extension beyond to see what other professional development and courses are offered.

Mr. Peter Kormos: Of course.

Mr. Dave Levac: Thank you very much, Mr. Chairman, and Dr. Franklin, thank you.

The Chair (Mr. Lorenzo Berardinetti): Thank you, Dr. Franklin, for coming today, and thank you for your presentation.

Dr. Alexander Franklin: Thank you.

The Chair (Mr. Lorenzo Berardinetti): Members of the committee, that completes our list of deputations for today. The committee now stands adjourned and will meet again on Thursday, April 2, 2009, at 2 p.m.

The committee adjourned at 1013.

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STANDING COMMITTEE ON JUSTICE POLICY

Chair / Président
Mr. Lorenzo Berardinetti (Scarborough Southwest / Scarborough-Sud-Ouest L)

Vice-Chair / Vice-Président
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