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Standing Committee on the Legislative Assembly

Protecting Patients Act, 2017

2nd Session
41st Parliament

Wednesday 26 April 2017

Chair: Monte McNaughton
Clerk: William Short

Journal des débats (Hansard)

M-16

Comité permanent de l'Assemblée législative

Loi de 2017 sur la protection des patients

2e session
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Mercredi 26 avril 2017

Président : Monte McNaughton
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON THE LEGISLATIVE ASSEMBLY

COMITÉ PERMANENT DE L'ASSEMBLÉE LÉGISLATIVE

Wednesday 26 April 2017

Mercredi 26 avril 2017

The committee met at 1234 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. I apologize that we're running a little behind schedule. We had a delay getting to question period today, so it delayed everyone's schedule.

Welcome to the Standing Committee on the Legislative Assembly. We're here to have public presentations on Bill 87.

MS. ELISABETH HALL

The Chair (Mr. Monte McNaughton): I'd like to call our first presenter, Elisabeth Hall. Good afternoon. Any seat where the light is, if you want. You will have six minutes for your presentation, followed by three minutes of questioning from each party. We'll begin with the official opposition. If you would state your name for Hansard, please, and then begin with your presentation.

Ms. Elisabeth Hall: My name is Elisabeth Hall. Thank you so much for allowing me to speak here today to express my concerns regarding Bill 87. I would like to take the time to address a few very important issues regarding this bill. But first, I would like to let you know a little bit about why this issue affects me and my family as well as many others in this province.

Years ago, I knew very little about vaccines. The only thing I knew was that they were "safe" and "effective." Then I had children. I submitted to my doctors' orders to bring them in for their routine checkups, where they were vaccinated by the recommended schedule at the time.

Fast-forward to today: Both my daughters have suffered chronic illnesses that have been associated with vaccines. Severe eczema, asthma, psoriasis, allergies, tics, irritable bowels and unknown chronic breathing issues are a few of the issues we have had to deal with so far.

It wasn't until my younger daughter developed chronic breathing issues that I was led to where I am today. As a mother, I needed to find the answers in order to help her. Since I come from a health background, I started down the rabbit hole, to research what had caused their chronic issues, as we exercise an extremely healthy lifestyle and have no health concerns at all that run in the family. Furthermore, what our doctors had given to them and prescribed for them did not work or help to heal them. So I began researching vaccines.

Because of this, I began to understand that vaccine injury was real, and it was more common than I thought. As I looked around, I saw many children who had also been injured. What really concerned me was that we were not told of any of these risks, harms, contraindications or injuries that could happen from a vaccine. I also had no idea about any reporting system that you could report any reactions to.

The more research I did, the more I saw that injuries were certainly not rare. In fact, the under-reporting of adverse events is an enormous problem for our passive vaccine surveillance system.

If the health and safety of our children is a priority, and vaccines have a risk of injury or death, then why are we not being told this?

"Deliberately concealing information from the parents for the sole purpose of getting them to comply with an 'official' vaccination schedule could thus be considered as a form of ethical violation or misconduct."

This denying of true informed consent begs the question: If forced, mandated vaccination sessions were required, would we be told the truth?

Another concern of mine is that there is no routine titre test done to determine if (a) we even need to be vaccinated, as natural immunity and breastfeeding produce antibodies to certain diseases; and (b) if the vaccine has produced the antibodies against said disease. The package inserts specifically state that it "does not protect all individuals."

If we are truly concerned for protecting the public against disease, why are we not routinely checking to see if people are actually being protected by the vaccine, or if people do not need to be vaccinated because they have the protection or the antibodies through natural immunity?

Having said all of that, I would like to bring up the mandatory educational sessions intended for parents who

would like to have a vaccine exemption. Spending money on educational sessions which would be forced on parents seems a bit ridiculous and a waste of money.

Secondly, it has been proven with a few different studies, as I have outlined here, that the parents who are choosing to follow a different schedule than the recommended schedule are very well educated individuals with a high level of education.

Furthermore, based on these studies, we see that "those who have actively chosen not to vaccinate or to selectively vaccinate have done so after many weeks and months of reading journals, books, articles, manufacturer's information, as well as all the information the NHS gives out.

"Parents who don't vaccinate usually know all of the vaccine ingredients, side effects and details of the diseases."

It appears the purpose for these education sessions could have an ulterior motive behind it. Parents who want an exemption for their child, in my opinion, probably have a good reason for wanting one, even though technically they do not need one as they are not mandatory. Whether it be a medical, religious, maybe a personal or a philosophical reason, parents should not be forced to attend an educational session on vaccines in order to get an exemption as this is a violation of our basic human right: freedom.

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Since these educational sessions would only be mandatory for parents who would like, or need, an exemption, the only logical explanation for these educational sessions would be to try to sway, coerce or mislead parents into vaccinating their child. This sounds a lot like coercion and not education.

Furthermore, Bill 87 violates the essential parameters of informed consent as articulated by Ontario's Health Care Consent Act, Canadian medical law and physician guidelines in obtaining consent to medical treatment—

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

Ms. Elisabeth Hall: Yes?

The Chair (Mr. Monte McNaughton): That's all the time for your presentation. The six minutes are up.

We'll move to Mr. Bailey from the official opposition.

Mr. Robert Bailey: Thank you, Ms. Hall, for your presentation today. You've got a great brief, looking through the submission here.

First of all, if I can ask, how old are your children now?

Ms. Elisabeth Hall: Eight and 10.

Mr. Robert Bailey: Eight and 10? Okay. I've got grandchildren that old. That makes me feel a little elderly.

Anyway, I guess the main thing about so long ago—I remember polio immunization when I was a child. At the time, there was no question. They brought the vaccine—as far as I remember; I was just a child. There was the fear of the disease and they wanted to stop the rampant spread of it. So it was very supported at the time. Maybe there wasn't the kind of public education that there is today, or the Internet. People can maybe self-educate more. So there wasn't the opposition; I never heard anything about this, I can be honest: until maybe 20 years ago, 25 years ago.

Do you see the medical profession's concern, that they're worried for the general good, the overall good, and that's why—

Ms. Elisabeth Hall: Right.

Mr. Robert Bailey: What's your opinion on that?

Ms. Elisabeth Hall: I see it as they're trying to protect individuals through vaccination. They're trying to protect communities; they're trying to protect nations. However, if protection is the issue, why are we not testing for titres? It makes no sense.

Mr. Robert Bailey: Yes. I didn't know that word; I'll be honest. I don't know "titre." What's that mean? I didn't know what that meant.

Ms. Elisabeth Hall: A titre test is where you actually do a test to see if your body has antibodies to a certain disease. People can actually have the antibodies to, let's say, measles or mumps without getting vaccinated. So they've come into contact with these viruses and their body has been able to build up the antibodies, so they wouldn't need to be vaccinated. But that's not taken into account; we just vaccinate everyone, whereas they might not need to be because they might have the antibodies already.

Mr. Robert Bailey: Thank you. Very good.

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

M^me^ France Gélinas: This is an interesting concept. Frankly, I never thought about that, that somebody would already have the immunity through some of the mandatory vaccines. Do you know of any other jurisdictions that do that, that test people before they have a universal vaccination program?

Ms. Elisabeth Hall: No. Nobody does a routine titre test, something where it's a regular test, like you go to the doctor's and you do a pap smear or something. You know you're supposed to do that every couple of years at a certain age. We're not routinely checking at all. In fact, I called OHIP and I asked them if the titre test was covered by OHIP, because I wanted to know if it was free and covered or if I had to pay for it. They did not know what a titre test was, so then they told me to call my doctor.

That's how rare this test is. As you can see, not many people know about it. But if we are routinely checking for titres, we can see if the vaccine is working, because we know that sometimes vaccine manufacturers have maybe set an efficacy of 95% but then they came back and said a couple of years later, "Oh, sorry, it was only 60%."

We can see that titre tests would be very important if you want to actually protect a community and protect individuals, because antibodies can transfer through breast milk. They can also come into contact—there have been people who have had titre tests who have never actually experienced the symptoms of the disease and had the antibodies for the disease.

M^me^ France Gélinas: Did you go to your family physician? Did you ask—if you were to be referred, is it covered?

Ms. Elisabeth Hall: Yes, it is covered.

M^me^ France Gélinas: But we're not using it because nobody knows about it.

Ms. Elisabeth Hall: Exactly.

M^me^ France Gélinas: How did you come to know about that?

Ms. Elisabeth Hall: I've been researching for a year and a half consistently, almost every day for, like, three hours.

M^me^ France Gélinas: It took a lot of work.

Ms. Elisabeth Hall: Yes, many sleepless nights.

M^me^ France Gélinas: Did you have such a test done on your children?

Ms. Elisabeth Hall: I haven't done a test, no, because they're fully vaccinated—and they were injured by vaccines. So I haven't done a test yet, but I probably will, just to see if the vaccines actually even worked.

M^me^ France Gélinas: Very interesting. Thank you.

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

Mr. John Fraser: Thank you very much, Ms. Hall, for being here and for your presentation. You did a great job. Is there anything else you wanted to add that you missed?

Ms. Elisabeth Hall: I'm okay. Thank you.

Mr. John Fraser: When I think of vaccines, I always think backwards in terms of things like smallpox, polio, measles and the public health crises we had. There's no question that vaccines are effective.

I do agree that it's people's choice and that people should make an informed choice. As you were saying, there are people who choose not to and people who choose selectively. Given the need for public health protection—because that's critical; that's why vaccines are there, to protect all of our health—and given that this legislation will not change a parent's ability to say, "No, I don't want that," what is the challenge with an information session?

I believe very well that you could make an informed decision, but I'm not necessarily sure—because the Internet is a great tool, but we also know that there's a lot of stuff on there that's not accurate. So in terms of people making informed decisions, it's not exactly the only tool. How do you see that?

Ms. Elisabeth Hall: These education sessions are supposed to be in place for people who want an exemption. They're not just for the average public, where anybody can go to get informed. If someone wants an exemption, they have to have maybe had an injured child that's—maybe their family history has the MTHFR gene that enables them to detox from toxins. They might have this gene, and they might want a medical exemption. I don't think they really need to be told they need to vaccinate.

The studies that I provided for you are showing you that the people who want the exemptions or who are choosing to do vaccinations selectively or on a different recommendation schedule are people who have done the research. They're highly educated. The people who are fully vaccinating their children and doing it on the schedule are actually the most impoverished people.

The education system looks like it's just kind of a waste of money or time when they could be using those for other purposes—for health. Health is a—

The Chair (Mr. Monte McNaughton): That's all the time for questioning from the government. Thanks for your presentation today.

Ms. Elisabeth Hall: Thank you so much.

ONTARIO COMMUNITY SUPPORT ASSOCIATION

The Chair (Mr. Monte McNaughton): I'd now like to call upon the Ontario Community Support Association, please. Good afternoon. You have six minutes for your presentation. If you would begin by stating your name for Hansard, that would be great.

Mr. Patrick Boily: Hello. My name is Patrick Boily. I am the manager of policy and stakeholder engagement with the Ontario Community Support Association.

I want to thank everyone on the committee for the opportunity to appear here today. I'd like to provide the perspective from the not-for-profit home and community care support services health sector on Bill 87, the Protecting Patients Act. More specifically, I'll focus on schedule 5 of the act, the proposed Seniors Active Living Centres Act.

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Currently, 38 of our members operate elderly persons centres, as they're currently known. In addition, OCSA represents over 270 non-profit agencies across the province who provide compassionate, high-quality home care and community support services to over one million Ontarians.

You are no doubt familiar with these organizations in your ridings that provide services to seniors and people with disabilities, such as in-home nursing and personal support, Meals on Wheels, Alzheimer's day programs, transportation to medical appointments, or supportive housing.

Our sector offers over 25 health and wellness services that support over one million Ontarians. This includes the delivery of over three million meals, over two million rides and over 250,000 clients served in adult day programs annually.

OCSA supports the bill's aims to enable more modern centres and to include partnerships with First Nation communities to operate these centres. OCSA supports the reduction in the administrative burden and the elimination of outdated regulatory requirements, such as the removal of capital requirements from the legislation to enable more innovative models. We also support the removal of the legislative caps on grant size and the retention of the municipal funding requirements.

However, OCSA strongly objects to the legislative change that would allow for-profit corporations to

receive and manage direct government funding for the operations of seniors active living centres.

The existing Elderly Persons Centres Act is specific that organizations must be charitable in nature. The new Seniors Active Living Centres Act's definition of "operator" includes for-profit corporations and entities. While OCSA supports changing the legislation to enable the funding of seniors active living centres in First Nation communities, it does not support changing the definition to include the delivery and operation of these services by for-profit corporations. The existing requirement that centres be non-profit has created an environment in which organizations that are grounded in and governed by their communities offer needed opportunities for socialization for seniors and rely on volunteers to deliver much of the programming. Volunteering is a key activity that helps reduce social isolation, ensures community vitality and enhances self-worth.

Placing the funding and operation of seniors active living centres in the hands of for-profit entities endangers these valuable qualities. Experience shows that people are unlikely to volunteer in for-profit environments. Volunteers at community support service providers across the province contribute over 3.5 million hours of service each year, a value of up to $85 million.

Another vital element of the not-for-profit nature of these centres is community governance. Community governance guarantees that the programming meets the needs of the local communities in which they operate. It allows for programs and services that are tailored to local needs and delivered in a culturally competent environment.

OCSA recommends amending the legislation to change the definition of an operator in the Seniors Active Living Centres Act to one that limits the receipt and management of funds to not-for-profit organizations while enabling First Nations communities to do the same. OCSA believes that if not-for-profit community groups want to partner and collaborate with for-profit entities, they should be able to do so, but that the receipt of these funds and the management of these funds and of the centres should remain in the hands of the not-for-profit community organization.

At this point, I would welcome any questions to further explain the rationale behind our recommendation.

The Chair (Mr. Monte McNaughton): Great. Thank you very much. We'll move to Madame Gélinas for three minutes of questions.

M^me^ France Gélinas: Merci d'être venu, Patrick.

M. Patrick Boily: Pas de problème.

M^me^ France Gélinas: Ça me fait plaisir de te revoir.

I've brought this issue forward to the government about why we are opening this in the act. When we went ahead with Patients First, which did the exact same thing for the LHINs, I opposed it. Their answer to me, "Oh, this is an ideology," that I am opposed to for-profit companies having the receipt and the management of funds for elderly persons centres. Were you able to get a better answer?

The second thing they told me is that it's so that First Nations could take part. I can safely say that any First Nation could open up an elderly persons centre right here, right now, without a change in the bill if there was money to be had. There haven't been any new elderly persons centres. What does the ministry tell you when you say they should limit the receipt and management of funds to not-for-profits?

Mr. Patrick Boily: In our conversations with the ministries, a similar rationale for the inclusion of First Nation communities was included. From our understanding, it's also that there was a requirement for municipal funding. The part of the bill that enabled that is a change in the language around municipal funding for First Nations and for-profit corporations. That was kind of the rationale given to us for that angle. But we believe that there is a way that you could write that to enable First Nations communities to receive the funding and still keep it for the not-for-profit sector. So that's what our recommendation is.

M^me^ France Gélinas: Okay, and are they open to that?

Mr. Patrick Boily: We are still in dialogue with them. We haven't had an answer either way.

M^me^ France Gélinas: Looking down the road, could you see where, if we agreed to pass the bill the way it is, a $5,000-a-month retirement home will start an elderly persons centre so that all of the elders get used to coming to their community room, the government will pay this for-profit company to hold an elderly persons centre, and, as grandma ages, she moves into the $5,000-a-month room in the home that she already knows? Am I stretching it here?

Mr. Patrick Boily: No. The way we see the bill, that could be a possibility: that for-profit corporations such as retirement homes could operate elderly persons centres if a municipality decided to partner with them, yes.

M^me^ France Gélinas: So is there a valid reason why the for-profit sector needs to come and help? Are you guys in need of support from the for-profit sector to do your job for elderly persons centres?

Mr. Patrick Boily: We don't believe that there's a need for that to happen. We believe that a lot of these organizations that are grounded in their community are able to manage, and do a good job at managing. That's why we talk about, at the end, having the opportunity that if community groups—

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

Mr. John Fraser: Did you want to finish that answer?

Mr. Patrick Boily: Sure. That's why we talk about, if community groups want to partner with for-profit corporations to do certain things where they don't have the capacity, that that should be within the framework as well.

Mr. John Fraser: Thank you very much for you're answer. My question was very similar to Madame Gélinas's, and you answered it very well. As that change

in the legislation was written, it creates flexibility. I understand what you're expressing, but also there's an understanding that the change in the legislation enables, as Madame Gélinas said, working with First Nations and some changes around municipalities.

I appreciate your comments in that regard. I think that, when you take a look at—there's also programming, right? When you go and write the programming and the policy, it's quite easy to stipulate inside there what you want. You could simply do that inside your programming.

There's a challenge there when you get into other communities where there's a limited number of physical facilities. It's the centre. I think that's the intent of that, but I very much appreciate your points in that regard. Thanks for being here.

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

Ms. Laurie Scott: Thank you very much for your presentation. I'm filling in for our critic, who could probably ask some more detailed questions, but is there anything else that you wanted to add? I listened to the discussion. Is there anything else that you wanted to add that maybe you didn't have time to get out that—it was very interesting, your profit/non-profit discussion.

Mr. Patrick Boily: I think to add to what MPP Fraser commented on, the idea that we've moved from where the old legislation was very restrictive in terms of what it had—it had capital requirements; it had a very strict structure of what it could be. These centres were, to a certain extent, handicapped in terms of their programming and what they could offer.

What we like that's in the bill is that it does open up a lot of these opportunities in terms of more flexible programming and more flexibility around the funding. But we still believe that these community groups that operate these centres add something else that would be taken away in a for-profit environment. Some of these really do operate in the basements of churches, and they're very much community-focused.

For seniors and vulnerable seniors, this offers an important opportunity to go beyond simply offering these small services—the importance of socialization, of volunteering and of community building that exists within these centres. I think it would be a wasted opportunity, a wasted capacity, that exists in the community, by opening it up to for-profit corporations.

Ms. Laurie Scott: Okay. I certainly have a lot of those organizations. So you're concerned that programs in church basements, for example, would not exist the way they do—

Mr. Patrick Boily: It's not necessarily that they wouldn't exist, but it would add a layer of competition and a layer of where you would see certain government funding being allocated for, to a certain extent, profit-seeking rather than community building. I think there's a certain amount, when we're looking at—these are not massive programs. We see the logic of having efficiencies being built into these programs on a massive scale, which sometimes the for-profit can offer; whereas, in these community programs, there is more of an aspect of community building toward them.

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Ms. Laurie Scott: Thank you.

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

COLLEGE OF PHYSIOTHERAPISTS OF ONTARIO

The Chair (Mr. Monte McNaughton): We'll call now the College of Physiotherapists of Ontario. Good afternoon. You have six minutes for your presentation. If you would begin with your names, and then after your presentation, the government will start with questioning.

Mr. Stephen Mangoff: Good afternoon. My name is Stephen Mangoff. I am president of the College of Physiotherapists of Ontario, the regulator for Ontario's 9,000 physiotherapists. With me today is Mr. Rod Hamilton, our college's associate registrar, policy and quality.

I'm here today to offer comments on the changes that Bill 87 proposes to the Regulated Health Professions Act. I am not a policy expert or a lawyer, but I am a real physiotherapist with more than 15 years' experience working with real patients in Ontario.

Right now, I work in the big city. That city is Thunder Bay. You will get why I say that in a second when I tell you that I spent most of my career working in a small community hospital in Nipigon, where, for much of the time, I was the only physiotherapist in the community.

At one time or another, I saw much of the population of Nipigon in my practice. Some of them I saw once in the emergency room when they sprained their ankle in a softball game or at the hockey rink. Others I treated over long periods of time for chronic pain and other injuries.

I have told you I'm a physiotherapist, but why am I here providing feedback on regulatory matters? I am proud to tell you that I have nine years of regulatory experience serving my profession's regulator. I have been in the role of councillor, chair of the registration committee, vice-president, and now president of our college. In fact, my eligibility to serve on the council expires at the end of this month.

During my time at the college, I have been proud to have a role in ensuring quality care and protection of patients. At my college, we implement continuous quality improvement in everything we do. We are always looking at how our processes can do a better job of protecting patient interests.

My college welcomes Bill 87 and the opportunity to take a close look at the legislation which governs our college processes. My college is part of FHRCO, which is the Federation of Health Regulatory Colleges of Ontario. FHRCO made a detailed submission about some of the strengths and challenges of the proposed legislation earlier in your hearings schedule.

I won't reiterate the details here, although I would like to highlight a few issues. I am very sensitive to the need to protect patients from exploitation by health professionals. Health professionals should not date patients because we are privileged with a special level of trust and power over them. It also makes sense that we should not be permitted to date patients for a period of time after we stop providing care to them.

Bill 87 proposes that the law should define who patients are and help provide clarity about this issue. But I don't think that this simple definition will be helpful. It's easy to see that it would be wrong for a health care professional to begin dating a patient with a chronic condition—one who had been dependent on me over an extended period of time. But what about the patient I saw for five minutes in the emergency room?

Please understand: I am a happily married man, and my dating prime is far, far behind me. So I'm not asking permission to date anyone; I am observing that a one-size-fits-all definition of patient may not be the best approach.

The courts deal with this need differently, and in our FHRCO submission we suggest that the changes in Bill 87 should take a similar approach. We think the law should set out criteria for determining who a patient is for the purposes of sexual abuse. These criteria might include sharing of personal health information; reliance on the practitioner for help in making health care decisions; and assuming that the practitioner will continue to provide services.

The other item in the bill that I wanted to talk about is the list of sexual acts that would result in revocation. I don't know about you, but over the years I have been shocked to see some of the forms that sexual abuse may take. The list makes an effort to capture all of these, but I think a list is the wrong approach. I think that there is another area where providing a framework that helps colleges determine whether something is abuse or not would be more helpful and flexible than a list.

Finally, as a health professional I'd like to address something that the FHRCO submission does not speak to. This is about the proposed power the minister will have to release personal information about me if it is needed to protect the public interest.

As a health professional, it is my duty to put patients' interests first. I understand that this might mean an intrusion into my privacy if I have jeopardized patient well-being. I have always understood that the patient comes before me. So if that means that my privacy has to be invaded so that patients are safer, I am okay with that.

In summary, I would like to say that my college and I would be happy to help the government make the changes needed to protect the public. I think our experience and our commitment to continuous quality improvement will make sure the changes that get made don't make things worse.

Thanks for giving me the opportunity to speak to you today. Any questions?

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

Mr. John Fraser: Thank you very much for your presentation, Mr. Mangoff, and for your comments. I do want to say on record that my physiotherapist, Sue Reive, has been great with me. I messed up my back about two weeks ago. I just saw her on Friday, so I can tell her she's in Hansard now. Sorry about that; I had to do it.

Mr. Stephen Mangoff: It's okay.

Mr. John Fraser: I'm interested that you feel that we shouldn't be listing specific sexual acts, that we should give it a general framework. I guess, when I look at that it's a concern about whether you can create a framework that's not open to interpretation.

Mr. Stephen Mangoff: My feelings on that are that a list could be restrictive, whereas a framework maybe opens it up. I had the experience of talking to a sexual abuse survivor this week, actually. Just about anything can be sexualized, especially in this day and age, so a list may not be the way to go. That's what I think we're getting at there. It's about the nature of the act or the intent of the person who is committing the act.

Mr. John Fraser: Yes, and I see what you mean by openness, but then, also, the interpretation is the thing that you have to watch out for.

Mr. Stephen Mangoff: So I think there's always room for compromise, or some combination thereof.

Mr. John Fraser: Thank you very much.

The Chair (Mr. Monte McNaughton): Sorry, was that it, Mr. Fraser?

Mr. John Fraser: Yes.

The Chair (Mr. Monte McNaughton): Okay; sorry. We'll move to the official opposition and Ms. Scott.

Ms. Laurie Scott: Thank you very much. I was trying to read the rest of your submission quickly, because there are other areas. My one question is, and then I'll let you—if you wanted to add anything to your presentation: Do you have definitions? When you were saying about changing definitions, especially of who a patient is, do you have any best practices that your association has seen or can recommend to the committee?

Mr. Stephen Mangoff: I think that the couple of suggestions that we made, that a sharing of health information might be a criterion; the reliance on the practitioner for making health choices would be a big one—that relationship; and then, about the ongoing provision of services. With Mr. Fraser's physiotherapist, he assumes that he would be continuing to have a relationship with her in a professional role, it sounds like to me. So those kinds of things can help define what a patient is in that moment in time, whereas, like I said, giving somebody a set of crutches perhaps doesn't meet that criteria. If all you've done is, really, provided them with some crutches in an emergency room, does that constitute them being your client or your patient? I just want to make that clear.

Ms. Laurie Scott: Okay. All right. That's fine. Thank you.

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

M^me^ France Gélinas: Thank you for coming all the way to Queen's Park. I appreciate the effort you've put in to come and talk to us today. Just so we make it clear, if we were to keep a definition that says "mandatory one year," what kinds of dangers would that cause to physiotherapists who are the only game in town in a town where they see everybody?

Mr. Stephen Mangoff: I often get asked that question at council tables because I am the one who practises in the smallest environment. I don't think there's harm to the physiotherapist who is, perhaps, the sole practitioner in that community. I don't think there's harm to him or her to have to wait a year to date somebody. It's just that there could be retention issues. It does run into some issues. If we can keep people interested in the community and some of the interest is perhaps by dating somebody in the community, then we are more likely to retain them in our small communities.

It's not that it's a big risk to the physiotherapists themselves, but I think there is certainly room for maybe losing some physiotherapists occasionally from small communities.

M^me^ France Gélinas: In your years with the college, have you had to discipline someone because of a sexual nature, and have you taken the licence of one of your physiotherapists away because of a sexual nature?

Mr. Stephen Mangoff: Can I pass that on to my colleague Rod?

M^me^ France Gélinas: Sure.

Mr. Rod Hamilton: We have.

M^me^ France Gélinas: Okay. How many, and when?

Mr. Rod Hamilton: I'm afraid I didn't bring that specific information with me, but it's more than one and it's over the course of the last 10 or 12 years, probably.

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M^me^ France Gélinas: Okay, so it does happen—

Mr. Rod Hamilton: It does happen.

M^me^ France Gélinas: —and you feel your college has been effective at dealing with them?

Mr. Rod Hamilton: We believe that we have been, yes.

M^me^ France Gélinas: Do you feel that right now you need changes to be able to protect the public from the physiotherapy act? Did you need this change for people to be protected?

Mr. Rod Hamilton: Which change were you referring to?

M^me^ France Gélinas: Bill 87.

Mr. Rod Hamilton: I think there are some good changes in the bill that clarify our authority and allow us to act quicker when those needs arise, so I think there are changes in there that are very valuable, yes.

Mr. Stephen Mangoff: And I concur with that. I think it's the speed of being able to take somebody's licence or suspend somebody's licence immediately when we learn of something of a sexual nature. I think that is a very important aspect of Bill 87 because it then takes away the possibility of that person injuring another person.

M^me^ France Gélinas: And you did not have this authority before?

Mr. Stephen Mangoff: We did not.

M^me^ France Gélinas: So this is a good step?

Mr. Stephen Mangoff: Absolutely.

M^me^ France Gélinas: We're going in the right direction?

Mr. Stephen Mangoff: Yes, ma'am.

M^me^ France Gélinas: I, too, tried to look at that very quickly—your drafting suggestion for an amendment—

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

FÉDÉRATION DES AÎNÉS ET DES RETRAITÉS FRANCOPHONES DE L'ONTARIO

Le Président (M. Monte McNaughton): Maintenant, nous avons la Fédération des aînés et des retraités francophones de l'Ontario. Bonjour.

M^me^ Carmen Gauthier: Bonjour.

Le Président (M. Monte McNaughton): Merci beaucoup.

You'll have six minutes for your presentation, followed by three minutes of questioning. I would remind committee members that you each have an earphone, and the translator is here to interpret this presentation.

M^me^ Élizabeth Allard: Mon nom est Élizabeth Allard, et je suis la présidente de la Fédération des aînés et des retraités francophones de l'Ontario. J'ai ma collègue avec moi, M^me^ Carmen Gauthier, qui s'occupe du dossier dont nous allons parler aujourd'hui. Nous sommes des bénévoles, mais on traite nos dossiers avec beaucoup de professionnalisme.

Notre fédération des aînés et des retraités a été fondée en 1978. Elle comprend à peu près 255 000 francophones de 50 ans et plus domiciliés en Ontario. Elle regroupe une soixantaine de centres de vie active et de clubs de langue française.

Lorsque vous aurez notre mémoire, qui n'est pas tout à fait complété, évidemment, vous aurez en annexe—mais déjà vous avez dans le livret qu'on vous a distribué la répartition de nos centres de vie active.

La FARFO a été de toutes les luttes importantes qui ont façonné la francophonie ontarienne. Nous avons participé à plusieurs comités provinciaux, et on se positionne, évidemment, à sauvegarder les intérêts des personnes âgées dans les dossiers suivants : la santé et les soins de longue durée, et le secteur juridique, incluant la prévention des abus et de la fraude.

Aujourd'hui, évidemment, nous parlons de centres de vie active. À quoi sert un centre de vie active plus spécifiquement pour les francophones? Étant donné que nous sommes en minorité et que l'Ontario est grand, nous sommes un peu éparpillés à la grandeur de l'Ontario. Il est important que des centres de vie active francophones permettent d'offrir, dans leur propre environnement, aux

personnes aînées franco-ontariennes, de vivre en français dans leur communauté.

Un centre de vie active permet à la personne âgée—et quand on parle de « âgée », on ne veut pas dire nécessairement de 80 ou 90 ans. On dit à partir de 50 ans que vous êtes un aîné. Que vous aimiez ça ou non, c'est ça. Alors, on a différents groupes d'âge. Ces groupes d'âge ont eu un vécu différent, ont eu une carrière différente—d'autres, pas de carrière—alors il ne faut pas oublier les personnes de 55 ans à 60 ans ou de 65 à 70 ans. Ce sont des aînés. Ils ont des besoins différents.

Le centre de vie active francophone en milieu minoritaire doit permettre à la personne âgée d'être exposée à un environnement qui vise à favoriser le développement de son sentiment d'appartenance à la communauté francophone. C'est une question de culture. C'est une question de garder notre culture. C'est une question de passage aussi d'héritage à nos enfants, à nos petits-enfants et à toute la génération à venir.

La Loi sur les services en français garantit aux francophones le droit de recevoir des services en français de la part des ministères et des organismes du gouvernement de l'Ontario situés dans l'une des 26 régions désignées de la province. Le projet de loi 209 vise à élargir l'accès à l'aide financière pour la création et le fonctionnement d'un programme de vie active s'adressant principalement aux personnes âgées, et prévoit que le prestataire de ce programme sera agréé par un directeur nommé par le ministre.

Il est important dans la nomination de ces gestionnaires et de ce directeur que le gouvernement s'assure que ce soit des personnes bilingues. Alors, la FARFO recommande—et je veux dire à ma collègue : vas-y.

M^me^ Carmen Gauthier: Oui, parce que je vois qu'il nous reste deux minutes, je pense.

Ce qui est important, c'est que le projet de loi 87 sur les centres de vie active respecte la Loi sur les services en français, et ça, dans toute sa totalité par rapport à la désignation des postes, etc. Puis, ce qui est important—on a une série de recommandations qu'on va vous remettre à cet effet-là.

Maintenant, vu qu'on a peu de temps, on veut également parler un petit peu du financement, parce que le but de cet exercice c'est de moderniser la loi et aussi de rendre accessible de nouveaux fonds à des groupes d'aînés qui sont sur la liste d'attente depuis quatre ou cinq ans. Il n'y a aucun financement disponible pour des nouveaux centres depuis près de cinq ans.

Nous, ce qu'on voudrait, c'est de voir que ces fonds permettent de rectifier la répartition géographique des centres et de répondre aussi aux besoins des francophones, des immigrants francophones et d'autres, parce que, comme des réseaux, on essaie d'intégrer et de rejoindre la population immigrante.

Une des recommandations, c'est de voir à ce que les fonds soient augmentés pour permettre la création d'un nouveau centre, parce qu'on constate que présentement il y a un accès inégal—

Le Président (M. Monte McNaughton): Merci beaucoup.

M^me^ Carmen Gauthier: D'accord.

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

Ms. Laurie Scott: I am more than happy to give you some of my time if you want to finish your presentation, because I feel like you were rushed.

Ms. Carmen Gauthier: Yes, we were rushed.

Ms. Laurie Scott: If you want to take a couple of minutes and make the points, I am more than happy. Go ahead.

M^me^ Carmen Gauthier: Peut-être 20 secondes—pas longtemps. On voudrait que le gouvernement de l'Ontario développe un programme pour financer les centres de vie active francophones dans des régions où les francophones sont dispersés, et ça, sur des grands territoires à la fois urbains et ruraux. J'ai un exemple à vous donner, et ça, c'est pour développer davantage les programmes et services en français.

Dans certaines municipalités comme la région de Peel, il y a des règlements—vous savez qu'une partie de l'accès aux fonds présentement, c'est d'être agréé par les municipalités. Les municipalités ont différents critères et politiques. Présentement, la communauté francophone de Peel, c'est-à-dire Mississauga et Brampton, ne peut pas adhérer à l'agrément au niveau municipal à cause de leurs critères qui demandent que, pour l'un, 90 %, et l'autre, 80 % de leurs résidents soient membres de notre groupe Retraite active de la municipalité. On est dispersé. Ça constitue une barrière à l'accès. Si nous ne sommes pas agréés par la municipalité, on ne peut pas avoir accès au financement de la province.

Le projet de loi, à cet effet-là, prévoit de peut-être financer des nouvelles entités prestataires. La définition de ces entités prestataires n'est pas claire, à notre avis, et on aimerait pouvoir obtenir plus d'aide de ce côté-là.

M^me^ Élizabeth Allard: Vous avez reçu une petite brochure là. Ça vous donnera une idée, justement, de ce que nos centres de vie active font. Alors, ça vaut la peine de continuer, et d'améliorer même, le financement. Le vieillissement de la population est là.

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M^me^ Carmen Gauthier: C'est une question de santé, de promotion de la santé et de prévention des maladies, parce que la plupart des centres pour personnes âgées qui vont devenir des centres de vie active visent vraiment la santé intellectuelle, physique et émotionnelle par des programmes qui sont de plus en plus appropriés. Ça nécessite aussi que le gouvernement accepte d'investir à ce bout-là dans les dépenses pour diminuer les dépenses reliées à d'autres types de problèmes reliés à l'isolement, où il y a des problèmes qui pourraient être corrigés avec une vie plus active des aînés dans la communauté.

Le Président (M. Monte McNaughton): Merci. Madame Gélinas.

M^me^ France Gélinas: Merci beaucoup, madame Allard, de venir. Ça me fait toujours plaisir de vous revoir. Parce que mon temps est limité, j'aurais des questions précises sur lesquelles je voudrais vous entendre.

Moi aussi, je suis inquiète de la définition des entités prestataires. Avec l'ouverture vers le privé, est-ce que ça veut dire que les prochains centres appartiendront à des entités privées? Ça me fait peur.

On a besoin d'un changement dans la loi pour que des centres de vie active qui couvrent plus qu'une municipalité, comme c'est souvent le cas pour les francophones, soient là, si je vous ai bien entendue?

M^me^ Élizabeth Allard: Oui.

M^me^ France Gélinas: OK, ainsi que de respecter la Loi sur les services en français. Est-ce que tu as un exemple concret à me donner où le manque de respect de la loi vous cause soucis?

M^me^ Élizabeth Allard: Oui, parce qu'on a des endroits où certains centres ont fermé à cause des distances aussi. Alors, les gens se dirigeaient vers des centres anglophones. C'est une perte, mais dans le Moyen-Nord, c'est le cas, et dans le Grand Nord encore plus, parce que les distances sont tellement grandes.

Il faut collaborer. Il faut donner plus d'argent pour que les régions plus éloignées ou plus distancées l'une de l'autre puissent s'amalgamer d'une certain façon.

M^me^ France Gélinas: Et aussi respecter la Loi sur les services en français. Quand on sait qu'il y a des centres qui demandent à ouvrir depuis longtemps et qui demandent de financement, mais il n'y en a plus de financement pour les centres, est-ce qu'on a des centres francophones là-dedans qui attendent? Lesquels?

M^me^ Carmen Gauthier: Entre autres, Retraite active de Peel : nous traitons avec deux municipalités et nous traitons avec deux RLISS, parce que notre population est répartie sur un grand territoire. Chaque municipalité a ses critères qui, en ce moment, nous refusent l'adhésion. Ce n'est pas parce qu'ils ne veulent pas, mais leurs critères—alors, là, on fait des démarches auprès des deux municipalités, ainsi que la région de Peel, mais c'est vraiment les municipalités qui ont ces fonds-là.

Nous sommes des contribuables, on paie nos taxes, et on aimerait pouvoir avoir ces petites cotisations éventuelles qui représentent à peu près 20 % d'un budget, soit sous forme d'argent ou d'installation de salles. Les centres pour personnes âgées dans ces deux centres urbains sont pleins à craquer. On a essayé d'obtenir des salles, on a essayé d'offrir nos programmes, et il n'en est pas question. C'est impossible.

Alors, les centres actuels ont beaucoup de pression, les centres comme le nôtre, et il y en a probablement d'autres dans le nord de l'Ontario—Elliot Lake, en particulier, peut-être. Nous, on est en attente depuis trois ou quatre ans, et on ne peut même pas soumettre une demande.

Le Président (M. Monte McNaughton): Merci. Monsieur Fraser.

M. John Fraser: Bonjour, madame Allard et madame Gauthier. Merci d'être ici aujourd'hui et pour votre présentation. Aussi, je vous remercie de votre travail pour répondre aux besoins des personnes aînées franco-ontariennes.

Nous savons que les services en français sont très importants pour les personnes aînées, en particulier les personnes qui souffrent de démence ou d'autres conditions cognitives, et—un moment. Mon français, c'est—I'm not too fast. I might go in English; we've only got three minutes.

How do you see this legislation providing greater flexibility for you to be able to work with other partners to make sure you deliver those francophone services that people need?

Ms. Élizabeth Allard: It would give us flexibility, yes, of course, parce que—

M. John Fraser: En français, si vous voulez.

M^me^ Élizabeth Allard: Ça va. Le problème, comme je disais—ce n'est pas le problème; il ne faut pas dire un problème, jamais. La situation aujourd'hui, c'est les différents âges de nos aînés et les différents groupes d'aînés.

Évidemment, les besoins ne sont pas les mêmes. Alors, dans une municipalité, il peut y avoir plus d'aînés de 80 ans et plus. Par contre, ce n'est pas la situation dans une autre municipalité, où c'est peut-être en partie des jeunes retraités. On parlait d'Elliot Lake tantôt. Elliot Lake, c'est maintenant un bassin de retraités qu'il y a là.

Oui, ça va donner de la flexibilité, mais il faut que le financement soit là.

M. John Fraser: Oui, je sais. Merci.

Le Président (M. Monte McNaughton): Merci beaucoup pour la présentation.

M^me^ Élizabeth Allard: Merci beaucoup de nous avoir reçues et si bien écoutées. Merci.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair (Mr. Monte McNaughton): We'll now call upon the Registered Nurses' Association of Ontario. Good afternoon. Please state your names for Hansard, and then you will have six minutes for your presentation.

Ms. Lisa Levin: I'm Lisa Levin.

Ms. Cheryl LaRonde-Ogilvie: Cheryl LaRonde-Ogilvie.

Ms. Lisa Levin: Good afternoon. Thank you for this opportunity to address the Standing Committee on the Legislative Assembly. My name is Lisa Levin. I am the director of nursing and health policy with the Registered Nurses' Association of Ontario. With me today is Cheryl LaRonde-Ogilvie, a registered nurse and nursing policy analyst with RNAO.

As the professional association representing registered nurses, nurse practitioners and nursing students in Ontario, we thank you for the opportunity to provide advice regarding Bill 87. RNAO will respond to schedules 3 and 4, and today we will be specifically commenting on five of the recommendations in our submission.

RNAO has been a staunch advocate for the full utilization of nurse practitioners, whom I will refer to as NPs. Thus, RNAO sees the inclusion of NP under the provisions of the Ontario Drug Benefit Act as central to facilitating the changes to Nursing Act regulations

announced on April 19 that permit NPs to prescribe controlled drugs and substances in Ontario.

As stated by Minister Eric Hoskins, authorizing NPs to prescribe controlled drugs and substances will provide faster access to care for Ontarians dealing with pain, anxiety and/or needing palliative care, as well as those living in rural and remote areas. It will also provide access to medical assistance in dying in accordance with the law.

While RNAO welcomes this long-awaited change to the scope of NP practice, some medications are still restricted for NPs working in palliative care and other areas and will remain so unless legislative and policy changes to the Exceptional Access Program are implemented. Currently, requests for coverage of drug products not listed in the Ontario Drug Benefit Formulary are restricted to physicians through the Exceptional Access Program.

Our first recommendation is to proceed with the inclusion of NPs, known in the act as "registered nurse in the extended class," in the ODBA and ensure that NPs are included under all relevant sections to maximize access to all medications within their scope of practice.

RNAO also wants to make a recommendation regarding registered nurses. On February 23, at our Queen's Park day, the Minister of Health announced that he is bringing forward amendments to the Nursing Act this spring to give RNs the authority to independently prescribe medications and communicate diagnoses. This will improve access to quality health services across the system and will enhance patient outcomes. As the province moves forward with this scope expansion, it should be anticipated that the ODBA will require amendments to include registered nurses.

Our second recommendation is to amend the ODBA to include registered nurses in anticipation of their expanded scope of practice.

Ms. Cheryl LaRonde-Ogilvie: Consistent with RNAO's best practice guidelines and ongoing advocacy against sexual violence, RNAO supports the strictest sanctions possible in the movement towards zero tolerance of sexual abuse by a health care provider.

There appear to be serious and persistent problems among regulated colleges in relation to weak enforcement and penalties of sexual misconduct by their members. RNAO formally presented to the minister's task force and called for stronger mandatory reporting requirements, better support services for patients who have been sexually abused and more education for health care providers.

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The people of Ontario place a great amount of trust in our health system and the health care professionals from whom they seek assistance in a time of need. That is why the numerous stories of abuse by health care providers are so upsetting. It is completely unacceptable that health care professionals accused of committing a sexual offence against a patient are allowed to continue to practise. This clearly demonstrates that the existing system has failed to uphold its mandate.

It's important to mention that this is the third task force report that has been convened over 15 years on this issue. The long history of negligence in pursuing and punishing the perpetrators of patient abuse needs to end in order to restore faith in our health system. If the government really wants to achieve zero tolerance, it needs to take immediate action and make real changes in the pursuit of this goal.

Accordingly, RNAO's third recommendation is to amend Bill 87 to mandate the creation of a new centralized regulatory body and independent tribunal to oversee all cases of alleged sexual abuse of patients by members of a professional college, with the minister's oversight, to sustain accountability, as outlined in the minister's task force report.

Our fourth recommendation is to proceed with the RHPA amendments proposed in schedule 4 of Bill 87 to give regulatory colleges more power to protect the public by issuing interim suspensions to members accused of sexual misconduct and mandatory revocation of a member's licence if found guilty. One of the most common human responses to sexual abuse is denial. As a result, disclosure of abuse is often hidden. It can take victims years to report the offence.

The definition of "patient" in the RHPA needs to be standardized across the professions and not be limited to the start and end of the formal treatment period. RNAO recommends using the language and definition of "patient" outlined in the minister's task force report—

The Chair (Mr. Monte McNaughton): Thank you very much. The six minutes are up.

We'll move to Madame Gélinas, please.

M^me^ France Gélinas: Thank you. It took a lot of courage for RNAO to come and say, "We will take away what has been done by 26 regulatory colleges and give it to a new body." You are not the only one, though. Certainly, the minister's task force report went there.

How important is it for you that this be done? I know that you have hinted at how important it is to maintain trust in the system, but could you elaborate? The system has been there for a long time. It is a major shift, so there have to be strong reasons why we would do such a major shift. What are they? Convince me.

Ms. Cheryl LaRonde-Ogilvie: We believe that this creates a balanced approach, keeping in mind that regulated professions have more power than patients. We just feel that if you move to a centralized regulatory body and take that away from the colleges, that will be putting patients first.

M^me^ France Gélinas: What do you do with the argument that nurses know better what nurses have to do and if we give it to a regulatory body, there may not be a nurse there; they won't know what it is to provide nursing?

Ms. Lisa Levin: We've had three task force reports on this, and sexual abuse continues and is not addressed properly in many circumstances. So in all cases, for all regulated health professions, we feel it's important to move to an independent body so that we have an

approach that is fair and that is really patient-centred, because right now it's focused on the professions, and the resources are with the professions.

M^me^ France Gélinas: So the college would continue to exist to provide all other discipline—if you've stolen, if you've not met the standards of practice; all of this stays with the college. But the minute that sexual abuse is brought forward, then it would go to this new task force?

Ms. Lisa Levin: Correct.

M^me^ France Gélinas: Do you have the support of any college when you bring this forward? Who supports—the minister's task force did. Anybody else?

Ms. Cheryl LaRonde-Ogilvie: Sorry. Are you saying have we consulted with anybody else on this recommendation?

M^me^ France Gélinas: Sure.

Ms. Cheryl LaRonde-Ogilvie: This is just our recommendation. We are saying that we are supporting the minister's task force recommendations, and we're really saying that we need to put patients first when it comes to this issue, because there continue to be reports of sexual abuse—not to say that colleges aren't trying to handle those, but—

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

Ms. Soo Wong: Thank you for being here today. I also wanted to thank the RNAO for taking a leadership role in terms of implementing the Ontario Nursing Strategy, so I want to be on the record for that.

I know, Ms. Levin, you touched upon schedule 3. I want to go a little bit further. Under schedule 3 of the legislation, we are proposing to amend the Ontario Drug Benefit Act to allow NPs—in terms of prescribing diabetes strips and other nutritional products. Can you share with the committee how that would benefit the patients? I want to hear about the benefits for the patient as nurse practitioners, which your organization represents.

Ms. Lisa Levin: There aren't enough physicians in Ontario to serve the population, particularly in rural, remote areas and small towns. By having an expanded scope for NPs—now that they can prescribe the controlled substances and have a broader scope, that means it provides more access to patients across Ontario.

Ms. Soo Wong: Thank you.

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

Mr. John Fraser: No. Thank you very much.

The Chair (Mr. Monte McNaughton): Okay. Thank you. We'll move to Ms. Scott.

Ms. Laurie Scott: I will follow up on Ms. Gélinas's question about the ministerial task force, the recommendation that you have brought forward about having a separate, independent regulatory tribunal for sexual assault. What I think was asked was, among health care practitioners, can you tell us of other practitioners who have recommended that this be changed to an independent tribunal?

Ms. Cheryl LaRonde-Ogilvie: I don't know if there are other practitioners who are supporting the minister's task force. I'm sure during the hearings, the people who are coming to speak to this bill will speak to their recommendations, but from the RNAO's perspective, we are supporting the minister's task force report and the recommendations in the pursuit of zero tolerance for sexual abuse.

Ms. Lisa Levin: We're representing the patients in that respect. You're asking about practitioners, but what we're trying to say is that we need to have a view that's patient-centred.

Ms. Laurie Scott: I definitely hear you. I would just, in a political movement, say that health care practitioners—if there were some co-operation and working together to try to solve this very difficult situation that occurs with patients, to remedy a more modern, expedient type of dealing with the matter. That's what I was wondering, as to the co-operation of what can possibly be done.

I haven't been able to look through all of the secondary package of amendments. Is there an amendment that does specifically deal with it?

Ms. Lisa Levin: Yes.

Ms. Laurie Scott: Okay. That's fine. That's good. Thank you very much for your presentation, Cheryl. I appreciate it.

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

NURSE PRACTITIONERS' ASSOCIATION OF ONTARIO

The Chair (Mr. Monte McNaughton): We'll now call upon the Nurse Practitioners' Association of Ontario. Good afternoon. If you'd state your name for Hansard. You'll have six minutes for your presentation. The questions this time will begin with the government.

Ms. Theresa Agnew: Thank you. Hello, everyone. My name is Theresa Agnew. I am the chief executive officer of the Nurse Practitioners' Association of Ontario. Here with me today is Jane Fahey-Walsh, NPAO's director of policy.

NPAO is the professional association representing more than 3,100 nurse practitioners and NP students in Ontario. We thank the committee for giving NPAO the opportunity today to provide feedback on Bill 87, the Protecting Patients Act.

NPAO supports the majority of the amendments proposed to the various pieces of legislation, as set out in Bill 87. We will make remarks and recommendations regarding three of the schedules contained within the bill.

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Within the Regulated Health Professions Act, schedule 4, NPAO strongly believes in and supports zero tolerance for sexual abuse of patients. As self-regulated health care professionals, nurse practitioners must adhere to the College of Nurses of Ontario guidelines, standards, professional ethics and appropriate legislation in their practice, including in the establishment and development of an ongoing therapeutic relationship with their patients.

A therapeutic relationship is predicated upon ensuring patient safety, both physical and psychological.

NPAO supports the majority of proposed changes within Bill 87 that help to prevent sexual abuse and support patients who have been sexually abused. For example, we strongly support the elimination of gender-based restrictions.

As the professional association supporting excellence in care, NPAO will do everything within our power to support the safety of patients and nurse practitioners as this bill is enacted. We make the following recommendations to clarify requirements and further strengthen the bill:

NPAO recommends that the definition of the term "patient" be clarified to reflect the variability amongst practitioners and their relationships with patients. This is extremely important given the serious outcome that may occur, that is, the mandatory revocation of a practitioner's registration or licence to practise should a health care professional and patient engage in a sexual relationship within the one-year cooling-off period.

NPAO recommends that the definition be clarified to reflect the variability that health care professionals play in patient care. For example, the relationship between a pharmacist and patient when dispensing a medication in a one-off brief encounter is very different than the relationship that is established between an NP, as a primary care provider, and a patient over many years. Therefore, some discretion is needed.

In addition, it is important to clarify when the one-year cooling-off period starts and stops.

Recommendation number 2, regarding postings of findings on the public register: NPAO supports greater transparency on the public register. Indeed, CNO has already made extensive changes to support this greater transparency; however, NPAO does not support the proposed change of posting a "no finding" in relation to an incapacity proceeding. In this case, if an NP has no finding, this means that the member has been cleared in relation to the person's fitness to practise. This should not be posted. Reputational damage to the member could occur, and in addition, it is unclear what value this information would have for public safety and the public interest.

In addition, the bill defines the result of a hearing as follows: "Where the panel has made no finding," and indicates it "includes the failure to make a finding." This is unclear language, as panels always make a finding. Therefore, NPAO recommends the wording be changed to "including any finding that professional misconduct or incompetence was not proven."

The bill, as proposed, will broaden the minister's authority to request personal health information regarding regulated health professionals. It is not clear, based on these broad powers, the extent of members' personal health information that the minister might require. NPAO requests that more information be provided to clarify the circumstances when the minister may require information, and in addition, what protections could be put in place.

Point-of-care testing: For countless years, NPAO has advocated for changes to be made to this act—the Laboratory and Specimen Collection Centre Licensing Act—to enable nurse practitioners to provide point-of-care testing. Bill 87 provides an opportunity to include an amendment to enable point-of-care testing by nurse practitioners.

NPAO also strongly supports the proposed changes to the Ontario Drug Benefit Act. If passed, these proposed changes will ensure that diabetic test strips and nutritional products, if ordered by an NP, will be reimbursed to eligible patients under the Ontario Drug Benefit Program.

In addition, a nurse practitioner will be able to submit an application for drugs under the Exceptional Access Program.

Despite these very positive and long-advocated-for amendments by NPAO, a significant barrier for palliative care patients will remain. Under the current program, palliative care patients who require products and who are ODB-eligible need to access those products through the palliative care facilitated access mechanism under EAP. These programs are currently limited to physicians—

The Chair (Mr. Monte McNaughton): Thank you very much. Your six minutes are up.

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

Ms. Soo Wong: Thank you very much for being here today, and thank you for your comments and suggestions.

I want to be on record, Mr. Chair, that I have a nurse practitioner clinic in my riding: the Hong Fook nurse practitioner clinic.

I wanted you to go a little bit further in your presentation, but the Chair just stopped you. Schedule 3 of the Ontario Drug Benefit Act, specifically dealing with the palliative care piece—I know you got cut off, so if you want to spend my time to talk about that, that would be great.

Ms. Theresa Agnew: Thank you very much. I will ask my colleague Jane Fahey-Walsh to speak to that point.

Ms. Jane Fahey-Walsh: In terms of the amendments to EAP, as I said, we were very pleased to see them going forward, but the issue remains regarding access to palliative care drugs. Specifically, the current program to expedite access to those drugs is limited to physicians. The program is run by the OMA, and they have criteria, and the criteria is that the individual has to be a physician.

There is also form 8, which is another method by which the physician can access those drugs. But if the patient is of a nurse practitioner, then the nurse practitioner, despite the changes under EAP, will have to find a physician to fill out the form and then fax the form, so that can result in delay in treatment. Think about a patient who can't swallow their opioid medication or their pain medication anymore. There could be a delay of a couple of days before they have access to those facilitated drugs.

Mr. John Fraser: On October 1 of last year, the rules around facilitated access were changed, which broadened the definition of who could order those drugs. So what

you're saying is, they're still restricted to physicians, even though you can order those same drugs for another purpose.

Ms. Jane Fahey-Walsh: Correct.

Mr. John Fraser: So there's an exception under the ODB.

Ms. Jane Fahey-Walsh: Correct.

Ms. Theresa Agnew: This might be an administrative change. This is part of the OMA-MOH forms committee. But this continues to be restricted to physicians only.

Mr. John Fraser: I was a bit surprised when you said that this morning. So that's good; thank you for that information.

The Chair (Mr. Monte McNaughton): We'll move to the official opposition and Ms. Scott.

Ms. Laurie Scott: Was there anything else that you wanted to bring up that you didn't get time for? I'm okay if you want to take the time—

Ms. Theresa Agnew: Yes, I did feel like a bit of an auctioneer there, speaking as quickly as I could.

Ms. Laurie Scott: You can take my time to finish off or to make a highlight. I thank you for coming and presenting, so if you want to take a minute to—

Ms. Theresa Agnew: Yes, I did want to say that NPAO was delighted when nurse practitioners in Ontario gained the authority to prescribe controlled drugs and substances. But we do now urge the government to move forward with other changes that were not enacted under Bill 179 and to remove other barriers to patient access, including but not limited to point-of-care testing. Just to be clear, point-of-care testing includes doing a pregnancy test, dipping a urine and doing a glucometer check—which patients can do; they're authorized to perform this point-of-care testing. Nurse practitioners are authorized to order and interpret all laboratory tests, but under the Laboratory and Specimen Collection Centre Licensing Act, they're not authorized to do point-of-care testing. So we did see that within schedule 2 and within Bill 87 there is an opportunity for the ministry to move forward with that change.

In addition, we would just encourage further enactment of Bill 179. Several changes have yet to be proclaimed and/or finalized, including forms of energy such as CT scans, MRI etc. So we're just using this as an opportunity to nudge.

Ms. Laurie Scott: I appreciate you nudging; that's good. Thank you very much.

The Chair (Mr. Monte McNaughton): We still have one minute. Mr. Bailey?

Mr. Robert Bailey: I wanted to ask something—and I'm going to ask the doctors when they come up. I had one of my constituents come in, and he talked to his doctor—I know you're with the nurse practitioners, but you mentioned schedule 2. In a nutshell, she told the patient that the part of Bill 87 dealing with specimen procurement will negatively affect her practice. There may now be a requirement to get special designation—can you explain that, if you understand it? If not, I'll leave it till I get to the doctors. I just wondered what that meant, when you brought up schedule 2.

1350

Ms. Jane Fahey-Walsh: I think, if I'm understanding your question, that is in the context of requirements being applied to physician offices if they're performing laboratory and specimen collection in their offices. So I believe the concern is in relation to additional requirements that physicians in their own offices will be required to meet, but that's just my interpretation. I'm not an expert on that.

Mr. Robert Bailey: Okay, well, that's fine. The doctors know I'm going to ask it when it comes to them.

Ms. Jane Fahey-Walsh: Go ahead and ask the doctors.

Mr. Robert Bailey: Thank you.

The Chair (Mr. Monte McNaughton): And right on time. We'll move to Madame Gélinas, please.

M^me^ France Gélinas: It's always a pleasure to see you. Thank you for coming. My first question has to do with how important it is for you that we make changes to—I'm looking at recommendation number 3 that you've given to us—the expansion of ministerial powers to have access to personal health information about members, in this case, about nurse practitioners. You've basically asked us to make sure that we make it clearer. How important is this for you?

Ms. Theresa Agnew: I would say that every day, nurse practitioners, as health care providers and custodians of personal health information, take great care to protect the personal health information of their patients. This particular amendment would certainly allow the Minister of Health to access the personal health information of more than 300,000 health care providers.

We can appreciate that there would be extremely rare circumstances under which the minister would actually use that authority, but we would certainly want more pieces put into regulation that would ensure the protection—the security—of that information really, and a well-defined use of it given that this is such a serious issue.

In addition, we do appreciate that the minister now has the authority to go in and supervise regulatory colleges. That's a current authority. We feel that in the interest of public safety, if there is doubt about trust in the regulatory process, we encourage the minister to use that authority.

M^me^ France Gélinas: So you would like to see who would be allowed, for what reason—those kinds of things—directly in the bill?

Ms. Theresa Agnew: Yes.

M^me^ France Gélinas: Okay. I can assure you that for recommendation number 4, the NDP will try really hard to help you so that we finally get the point-of-care testing done. My goodness, it shouldn't be that hard or that long; should it?

For the palliative care piece, right now we have this system that is run by the OMA. Is there good collabora-

tion between you and the OMA to get this changed on the ground, or do you need us to mandate this to change?

Ms. Theresa Agnew: No, there's very good collaboration between NPAO and the OMA. We can work with them to ensure that changes are made.

M^me^ France Gélinas: Okay, so this is more to keep us up to date that this needs to change?

Ms. Theresa Agnew: Yes, and that this remains a barrier. Certainly, in terms of putting patients first, we want to ensure that patients have access to expeditious and efficacious care.

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

CANADIAN DENTAL PROTECTIVE ASSOCIATION

The Chair (Mr. Monte McNaughton): We'll now call upon the Canadian Dental Protective Association. Good afternoon.

Dr. Lionel Lenkinski: Good afternoon.

The Chair (Mr. Monte McNaughton): If you could state your name for Hansard, you can begin with your six-minute presentation.

Dr. Lionel Lenkinski: Lionel Lenkinski, and I'm the executive director of the Canadian Dental Protective Association. I'd like to thank the committee for the indulgence in letting us present to the committee today. The importance of us being here is that we truly are a defence organization, and I think it's helpful for you to hear our perspective, which is very much in line with the proposed act that is before the committee today.

I'll tell you a little bit about us. We're a mutual benefit association made up of Ontario dentists. Our mandate is to provide regulatory compliance risk management assistance and pay for legal defences and case-manage those when dentists wind up with regulatory proceedings before the Royal College of Dental Surgeons of Ontario. In the duality of my life I'm also a registered member of the royal college still, and have a specialty practice in Toronto part-time, so ultimately I'll be subject to the regulatory changes that become effected.

As part of the objects of our corporation, one of the main ones is to promote the ethical, safe and patient-centred practice for dentists in Ontario, and it's in that regard that I'm here. I'll limit my remarks to three areas: the area of transparency, the definition of a patient, and, ultimately, the composition of the ICRCs that will hopefully be looking at the allegations of sexual impropriety.

As a defence organization, it's also our belief that any type of sexual contact between patients and practitioners is intolerable, especially so when it's aggressive and predatory, either physically or even verbally or through electronic media, which seems to be a very growing concern.

Back when the transparency changes were mandated in October 2015, our organization had a lot of anxiety and trepidation about how they'd be applied. In fairness to the Legislature and RCDSO, the result has been nothing less than spectacular in that we found that the notion of having the public register hold information about actions that are taken against members, be they cautions, SCERPs, limitations or otherwise, where monitoring has given the committees a better eye as to when these actions should or should not be taken because the action had to become public, and we're all for it. We feel that for self-regulation to survive in Ontario, transparency is one of the hallmarks that has to be maintained. Again, we're a defence organization, and this is very critical to us.

In terms of the patient relationship, what's outlined in the act is entirely acceptable to us. We understand that when a patient comes to our offices, they are a patient. The problem is: When do they cease being a patient? Again, this is not a homogeneous situation. For practitioners like myself who see people for consultations and ultimately for one-off treatment, the question of when someone ceases to become a patient is a little less clear.

We, personally, understand that the 12-month attrition when someone does not attend a practice is what is written presently. In an ideal world, we'd like to see some kind of active process on behalf of both the patient and practitioner if they want to discontinue the relationship. Ideally, this would be in some kind of prescribed format. It's just something that the committee may wish to consider so that there is no question if they decide to enter into a sexual relationship, because notwithstanding the fact that the relationship may be 12 months and one day old, there's still the whole concept of the personal health information and other information that the practitioner contains in their own records relative to that patient.

The area that we have a special interest in is the issue of what happens when allegations of sexual impropriety are levied against a practitioner by a patient. We see that these—having the experience that we have—are entirely different than those where the allegations are of a breach of standards or some other misadventure that happens during the course of treatment. I can speak to that. As a professional being involved in this type of regulatory environment for the past 20 years, I would find myself feeling inadequate in terms of adjudicating the various issues that arise in sexual allegations. One is: Is the complainant still a patient? What about the evidentiary issues? What about the sexual acts that may not be listed in the regulations that will be forthcoming but may be equivalent?

To that end, I think, in terms of maintaining fairness in the eyes of the public and putting the public interest first, our suggestion is that at least one member of the panels of the ICRC that review sexual allegations receive some sort of specialty training or be selected from a pool of experts amongst the government-appointed community, and maybe even chair those committees. They lead the investigations because they are different than those that involve standards.

For those of you who have read today's Toronto Star, on the front page you will find a dentist who was revoked

by the RCDSO this week. Although it's a great result in terms of public fairness, my only concern is: Is this enough so that patients that are in a health care situation feel comfortable enough to come forward and levy a complaint against their practitioner, with the eye that they'll be dealt with in a fair manner, that their story will be heard and the facts will be considered on the basis of the actual facts, and that they'll have some kind of result that they feel is suitable to whatever misadventure and inappropriate act occurred?

The Chair (Mr. Monte McNaughton): Thank you very much. The six minutes are up. We're going to begin questions this time with the official opposition. Ms. Scott or Mr. Bailey?

1400

Mr. Robert Bailey: I've got one while Ms. Scott is thinking.

Ms. Laurie Scott: Go ahead.

Mr. Robert Bailey: I enjoyed your presentation. Just one question on the one year that's proposed for the duration of a patient/doctor relationship: How would it be? Would it be something signed by both parties, "Look, I'm no longer seeing this patient," or, "He's no longer my dentist"?

Dr. Lionel Lenkinski: Correct.

Mr. Robert Bailey: So it would actually be in writing, filed with the college? Where would it be filed?

Dr. Lionel Lenkinski: I'd suggest that it be filed with the college, because they're ultimately going to be the arbiters of anything that arises subsequent to this.

Mr. Robert Bailey: I just wondered how that was going to work. So you're looking at a written document?

Dr. Lionel Lenkinski: I think a written document is appropriate because you're going to get into the "he said/she said."

Mr. Robert Bailey: I just talked to—I won't say who. Anyway, I just talked on the phone about half an hour ago, and I said that we were at committee here and the dentists and the doctors are all here. This person—it was a lady—said that she went and had her wisdom teeth out. He was a professional ortho-whatever they are—

Dr. Lionel Lenkinski: Oral surgeon.

Mr. Robert Bailey: —orthodontist or whatever. They were going to start dating later on. He said, "I've got to go talk to my lawyer." This is long before this; I'm talking years ago. But he went and actually had to get legal advice. He said, "I've got to be really careful here."

I can see where the written submission could be a very good argument. But I wanted to understand what you were thinking.

Dr. Lionel Lenkinski: Correct. I think it should be filed with whoever the regulatory authority is for that particular profession in the province.

Mr. Robert Bailey: That's fine for me.

The Chair (Mr. Monte McNaughton): Ms. Scott, do you have any questions?

Ms. Laurie Scott: No, that's good. Thank you.

The Chair (Mr. Monte McNaughton): Okay.

Madame Gélinas.

M^me^ France Gélinas: Thank you so much for coming. Your members: Do they pay the fee themselves to belong, and do they all have to belong?

Dr. Lionel Lenkinski: No, it's a voluntary organization, and they pay the fee themselves.

M^me^ France Gélinas: So dentists who are not part of the protective association: How do they get insurance?

Dr. Lionel Lenkinski: They don't.

M^me^ France Gélinas: Ah, lovely. So it's not mandatory?

Dr. Lionel Lenkinski: It's not mandatory, and it's self-funded.

M^me^ France Gélinas: And it's self-funded.

Do you solely defend against regulatory practice? If they are caught stealing money or doing something that has nothing to do with dentistry, would they still be protected by your association?

Dr. Lionel Lenkinski: We believe that allegations are allegations until they're proven. If it's a commercial recovery by a third-party payer, we will not pay for legal defence at that point, but we will help them manage the process.

We stay away from issues that aren't in the public interest. If it's fraud, it's not in the public interest to have insurance for that. But we will give them cursory advice and tell them to retain their own counsel at that point.

In allegations of sexual impropriety, typically, depending on what the allegations are, it goes through our committee. It's not 100% that they will receive assistance at that point. It depends on the nature of the allegations and the facts that we see in terms of the complaint documents.

M^me^ France Gélinas: Oh, wow. So there would be many cases—

Dr. Lionel Lenkinski: It's discretionary.

M^me^ France Gélinas: It's discretionary. So when they pay into your association, they know that they're not covered for everything?

Dr. Lionel Lenkinski: They know that it's discretionary and it's not insurance.

M^me^ France Gélinas: That it's not insurance.

What percentage of dentists in Ontario who are practising dentists are members?

Dr. Lionel Lenkinski: About 25%, roughly.

M^me^ France Gélinas: Okay. Do you mind me asking how much the fees are on a yearly basis?

Dr. Lionel Lenkinski: It's in the area of around—with HST—roughly $1,250.

M^me^ France Gélinas: Okay. Would the fee increase if somebody already had a case and they're coming for the second or third time? Would their fee go up?

Dr. Lionel Lenkinski: No, but what happens is that we have the right to terminate membership through a vote of the board.

M^me^ France Gélinas: Have you ever done that?

Dr. Lionel Lenkinski: Yes, we have.

M^me^ France Gélinas: And what was that about?

Dr. Lionel Lenkinski: One was the sum total of the complaints that were filed against them in terms of the

number in a period of time. The other one was inappropriate conduct of a sexual nature.

We take a very dim view of this because we're a peer-to-peer organization. As we're self-funded, we don't think that we're a bank account for people to go out in the province and do what they feel like doing. If, during the normal course of events, something happens where they require assistance and legal representation, then we're behind them. We go by appropriate and—

The Chair (Mr. Monte McNaughton): That's all of the time for the questions from the third party. We'll move to the government and Ms. Wong.

Ms. Soo Wong: Thank you for being here. I wanted to ask: With regard to the proposed legislation, Bill 87, how do you see the improvement in terms of the RHPA, in terms of dental care and the whole profession called dentistry?

Dr. Lionel Lenkinski: First of all, we believe that the issue of transparency was a transformative moment in the practice of dentistry in Ontario, because with the way we manage our case files, for example, dentists do not want to be published on the register.

We're very aggressive in terms of trying to bring standards of care up. The complaint process has basically driven us to work with the members who have complaints and get them to take the remedial courses before the ICRC sets down its decision.

The overall standard of care: It's difficult for us to say if we have raised it. We feel that in the areas where people have had deficiencies, we've been able to improve the care with those who need it the most, who have repeated problems with record-keeping and certain technical issues. We have sent them back to school, as part of our assistance.

Ms. Soo Wong: As a defence organization—that's what you call yourselves—you're actually supporting the members in a proactive manner. Am I correct in hearing that?

Dr. Lionel Lenkinski: Correct.

Ms. Soo Wong: Okay. The other piece here is in terms of the changes. We want to make sure all the people of Ontario get fair and transparent care.

How do you feel about the changes in terms of the impact on Ontarians, in terms of dental care?

Dr. Lionel Lenkinski: For me, if we take our hats off—when I stop answering my phone and emails and become a patient, a parent, and a son to an elderly mother—the main issue is, how safe are those people when they go into any facility in Ontario? I think that's the hallmark. I firmly believe—and the reason I wanted to come down here as a defence organization—that this is commendable, and it will set the standard even higher and protect the public, which is what we're all here for.

Ms. Soo Wong: Thank you very much for your presentation and your submission.

Dr. Lionel Lenkinski: Yes. Thank you.

The Chair (Mr. Monte McNaughton): Excellent. Any further questions from the government?

Ms. Soo Wong: Thank you.

The Chair (Mr. Monte McNaughton): Thank you very much.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

The Chair (Mr. Monte McNaughton): We'll now call upon the College of Physicians and Surgeons of Ontario. Good afternoon. If you'd each state your name for Hansard and then begin your presentation. You have six minutes for your presentation, and the questions this time will begin with the third party.

Dr. David Rouselle: Thank you for the opportunity to appear before the committee. I'm David Rouselle, president of the College of Physicians and Surgeons of Ontario. I'm an obstetrician at Southlake Regional Health Centre in Newmarket.

Joining me are Rocco Gerace, college registrar; Louise Verity, director of policy and communications; and Vicki White, co-director of our legal department.

The College of Physicians and Surgeons of Ontario regulates the province's medical profession and has the mandate to serve and protect the public interest, a role we take very seriously.

Bill 87 is an important piece of legislation for Ontario's patients and health colleges. The college supports the intent and objectives which underpin the bill, namely, to strengthen the sexual abuse and transparency provisions of the RHPA and to improve the complaints, investigation and discipline processes.

Over the past several years, the college has strongly advocated for legislative change that will enhance our ability to protect patients from sexual abuse by physicians, and strengthen the penalties for such sexual abuse.

We do, however, note a number of significant concerns with the bill. To make the best use of our time, I'll focus on our most significant areas of concern. We have a detailed written submission to lay out our concerns and proposed drafting language.

Our most significant concern is the sweeping new undefined regulation-making authority with respect to the structure of the college's seven statutory committees. This authority is extremely broad, and will place important governance matters that are currently addressed in statute into regulations that are outside the legislative process.

We suggest an alternate and focused approach. We believe that there is an opportunity to enhance the integrity and accountability of college discipline processes by introducing bold statutory change—amendments to ensure that there is complete separation between the discipline committee and the council, with no overlap in membership between the two entities. This will enhance the integrity and perception of independence of the discipline process, and it will involve a broader pool of public representatives. We feel public representation is very important in the work of the discipline committee.

Looking at the definition of "patient," the bill proposes a definition for the purpose of sex abuse

allegations. We support the intended objective, but we have significant concerns with how the bill sets out to do this.

1410

First, the draft provision specifies that a patient is an "individual who was a member's patient within the last year" but doesn't state or define the incident to which that one-year period would be anchored.

Second, the draft provision only applies to sex abuse matters, whereas matters before the discipline committee can have mixed allegations: sexual and non-sexual. The existence of the physician-patient relationship would be relevant to both and yet the patient would be defined differently in the context of each allegation, which could increase the complexity of hearings and increase the risk of legal error by the discipline panels. We've made specific suggestions for remedying these problems in our submission.

In the area of protecting and supporting patients, generally the college is pleased that the bill includes a power for the ICRC, in serious matters, to restrict or suspend prior to a referral to the discipline or to the fitness to practise committees. Our submission also contains important drafting changes in this area.

Unfortunately, the bill doesn't address the use of private patient medical records, third-party records, during sex abuse hearings. This is a significant issue which we should address in order to respect patient rights and to avoid creating a chill effect amongst survivors with respect to their willingness to come forward to the colleges when they have been sexually abused. We propose amendments to raise the threshold as to when these patient records would have to be produced.

We also suggest an important amendment to clarify section 35(9) of the Mental Health Act to make sure it's not applicable to college hearings. This amendment is necessary to ensure that the college can access records necessary to assess the competence of physicians practising in psychiatric facilities without being subject to unnecessary and onerous processes that could be harmful to vulnerable patients. Again, our submission provides an explanation and suggests revisions.

In terms of support for public council members, we recommend a number of essential changes including matters of workload and compensation. These are serious issues; we've raised this many times over the years. Surely, there is an opportunity now to address this through amendments to the bill.

On a different tack, the bill does not currently address information regarding information sharing with police about non-physicians. The college is actually not permitted to talk to the police about those issues. During an investigation, we sometimes uncover significant issues such as non-doctors fraudulently hacking into members' systems, fraud in relation to accident benefits, or the trafficking of narcotics. We want to be able to share information in such cases with the police when there are reasonable grounds to believe that there is conduct that could constitute an offence.

Finally, with transparency, of course, the college is very supportive of increased transparency and has taken a leadership role in this area for the past several years. Our submission contains a number of important technical proposed revisions to the bill.

In summary, the college supports the intent of Bill 87 and asks, with respect, that the committee consider our submission and the drafting recommendations we have put forward to strengthen the bill. Thank you for letting us present. We would be pleased to answer questions.

The Chair (Mr. Monte McNaughton): Excellent. You've done this before; you were right on time.

We'll move to Madame Gélinas.

M^me^ France Gélinas: Thank you. I will be very blunt: Most of the time, when people complain against the college, they complain about you. They complain about one of your members having done something horrible to a patient and getting away with a slap on the wrist. All of the changes that we're asking to do—and some of them are pretty drastic—come from your members. Do you feel that the changes that are in here now will be sufficient to swing the pendulum to the other side to make sure that when your members do wrong, they get punished to the same extent as members of any other college who do wrong?

Dr. David Rouselle: I'm going to ask our legal director to speak to that. As a prosecutor, she is probably best positioned.

Ms. Vicki White: I'm happy to do so, or to have our registrar, as well, join in. I think that the sentiment you express is one that's important to consider, and that the college—

The Chair (Mr. Monte McNaughton): I'm sorry to interrupt. Would you just state your name, please, and then continue?

Ms. Vicki White: Vicki White.

The Chair (Mr. Monte McNaughton): Thanks.

Ms. Vicki White: The college has asked for legislative change to ensure that penalties for serious matters like sexual abuse are strengthened, and that committees that might otherwise have their hands tied by historical decisions that aren't reflective of today's views on sexual abuse are not prohibitive.

I think the college's position is that it would like the help of the Legislature to assist us in protecting the public and ensuring that penalties do in fact meet the very harsh reality of today, where committees are bound by precedent but want to reflect the profession's own concerns about serious matters like sexual abuse.

M^me^ France Gélinas: Does the fact that the legal defence for physicians comes from CMPA have anything to do with the fact that some of what the public finds outrageous ended up with minimal punishment from your end?

Ms. Vicki White: I think the physicians do have competent counsel defending their interests in a disciplinary proceeding. The extent to which the specific counsel representation is what leads to specific outcomes—I don't think I'm in a position to comment on that.

M^me^ France Gélinas: Okay. Dr. Rocco, did you want to add?

Ms. Louise Verity: If I may, I would say that the college—

The Chair (Mr. Monte McNaughton): If you could just state your name, please, for Hansard.

Ms. Louise Verity: Louise Verity. The college prosecutes these cases very aggressively. The interests of the college—a college acting in the public interest—sex abuse is—

The Chair (Mr. Monte McNaughton): I'm sorry. We're going to move now to the government for questions, please.

I would remind presenters, if you'd just state your name for Hansard, if you haven't already, before you answer a question.

We'll move to Mr. Fraser.

Mr. John Fraser: You can finish your answer to that question.

Ms. Louise Verity: Thank you very much. I was just going to say that the college prosecutes these cases quite aggressively and takes these sorts of issues very seriously. As part of our work and activity over the last number of years, we have put forward a number of changes to strengthen the legislation, and those changes are included as part of our response to Bill 87.

Mr. John Fraser: Thanks for that answer. I just want to concur with Madame Gélinas: There is a need for transparency. That's why this bill is here. It's obviously of concern to the public. I thank you for all the recommendations that you've made.

I have a question for you. We had the College of Physiotherapists here earlier, and they were suggesting a change around the definition of the sexual acts involved and, instead of having a listing of those acts, having something that could be broader in terms of inclusive. I didn't see that recommendation in your package. Do you have any comments on that?

Dr. Rocco Gerace: It's Rocco Gerace. We actually have made recommendations in the past, expanding the approach to sexual abuse so that revocation would be mandatory far beyond the definitions or, as we call them, the body-part allegations that we see. So we've made that recommendation in the past. We have not repeated it here, but we would be happy to share it if you'd like to see it.

Mr. John Fraser: That's great. Thank you very much.

The Chair (Mr. Monte McNaughton): Excellent. Any further questions from the government? We'll move to the official opposition, then: Ms. Scott.

Ms. Laurie Scott: I know that a priority you addressed are the issues of the allegations of sexual assault against the members and how you're dealing with them. Do you want to expand any more on your proposals and how they—say, a doctor that there are allegations against. Can you take me from that point, where there is a doctor who has allegations by a patient against them, and how this bill or the recommendations are going to change the process that exists presently, that you have in your college?

Dr. David Rouselle: Right. For example, I've spent a lot of time on ICRC. Oftentimes, when an allegation is made and it's a serious allegation, we are not able to take any steps to protect the public until we've conducted an investigation and eventually, where feasible, we have referred to a discipline committee, so there may be months or longer. Meanwhile, the public is at risk.

With the provision to allow ICRC to take an interim step—apply a term limit or condition—we will be able to protect the public in those circumstances. That's just one example.

Ms. Laurie Scott: In a faster period of time, or immediately.

1420

Dr. David Rouselle: Shortly after the allegation is laid, potentially. So that's an example. Is that what you were referring to?

Ms. Laurie Scott: Yes. I just wanted to get some action so that it can be clear.

I think that's all specifically on that. I don't know if—

Mr. Robert Bailey: Yes, I've got a question. I don't know whether you heard my submission to the last presenter. This was from a constituent of mine who visited his doctor. I was hoping you could explain this. She told him that part of Bill 87 dealing with specimen procurement, schedule 2, could negatively affect her practice. There may now be a requirement to get a special designation from the ministry as a specimen collection centre. Do you know anything about that, or is that not in your wheelhouse, as they say?

Dr. David Rouselle: I'm sorry, I wouldn't be able to speak to that.

Mr. Robert Bailey: Okay.

Ms. Vicki White: The submission in front of you focuses on schedule 4 to Bill 87. I believe you're referring to a different schedule, that being the specimen collection act—amendments not to the RHPA, but to the specimen collection act.

In answer to the earlier question from your colleague, we certainly have made a number of recommendations that we think are crucial to allowing colleges to properly protect patients. The goal of the bill is shared by the college, but we have some really important requests for amendments to facilitate the work of the colleges. Dr. Rouselle has just mentioned one of them, which is some amendments to the power to restrict members once allegations are received, which is an important amendment that we have emphasized. We've also made submissions—

The Chair (Mr. Monte McNaughton): Thank you very much. The three minutes are up.

Mr. Robert Bailey: Thank you.

The Chair (Mr. Monte McNaughton): Thanks for your presentation today.

DOCTORS FOR JUSTICE

The Chair (Mr. Monte McNaughton): We'll now call upon Doctors for Justice. Good afternoon. As with the other presenters, if you'd state your name, please. You have six minutes for your presentation.

Dr. Sharadindu Rai: Thank you, Chair. My name is Dr. Sharadindu Rai and I'm a family physician in London. I'm speaking today as president of Doctors for Justice. We welcome the opportunity to address this committee regarding Bill 87.

Bill 87 is another example of this government's pattern of unilateral decision-making and systematic disrespect for Ontario's physicians. Ontario's physicians have not been properly consulted regarding the content of this bill. Further, this bill also violates physicians' procedural right to a presumption of innocence until proven guilty, whereas sections of this bill require mandatory reporting of unsubstantiated complaints of a sexual nature.

Bill 87 also contravenes tenets of the Personal Health Information Protection Act in that the minister is given the authority to collect personal health information about physicians from the CPSO. Bill 87 also strips away procedural fairness to Ontario's physicians, and we have a very serious concern about it.

Although we fully support efforts to protect patients and fully endorse a zero-tolerance policy when it comes to sexual abuse, there is a real threat that this bill will lead to physicians feeling unsafe when it comes to performing routine medical care.

Ontario's physicians should not have to work fearing that unsubstantiated allegations of sexual abuse will forever mar their professional reputation. Although complaints of sexual misconduct constitute a very small proportion of the complaints received by the College of Physicians and Surgeons, it is not unusual for the CPSO's discipline committee to dismiss a number of these complaints after a thorough, impartial investigation. Bill 87 would make the mere referral of a sexual complaint to the discipline committee a matter of public record, even if the complaint is ultimately found to be completely unsubstantiated. Many physicians, out of a fear that conducting routine medical exams such as pelvic exams, Pap tests and breast exams may lead to a complaint of sexual abuse, will avoid performing these exams even when these exams are clinically indicated. CPSO's investigative process alone is traumatizing to physicians, much less the fear that unsubstantiated complaints of a sexual nature will become a matter of public record. The fear created by Bill 87 threatens to undermine patient care, not bolster it.

Bill 87 also proposes changes to vaccination reporting, to shift the burden of reporting routine immunizations from parents to providers. Apparently, the government of Ontario does not trust Ontario's patients to take charge of their own health. We should be taking steps to empower our patients, not disempower them. A yellow vaccination card is so easy to misplace. We should be creating an online provincial registry that is easily accessible by any patient, anywhere in the world. Any provider, in this jurisdiction or otherwise, would administer the vaccination, and the patient would enter the vaccination from the convenience of their own cellphone. This is the kind of innovation that Ontario needs, not reinforcement of the bureaucracy that already exists. Mr. Chairman, why can't our Minister of Health innovate instead of legislate?

We'll use this opportunity to point out the sections of Bill 87 that we take issue with.

Schedule 1, section 4, amending section 10(2) of the Immunization of School Pupils Act: The proposed amendment requires physicians to report all immunizations to the medical officer of health. It's our view that our health care system requires innovation, not further regulation. Instead of creating more bureaucracy, this government should be taking steps to modernize vaccination reporting through a harmonized, online e-vaccination portal. This section should be substantially amended or redacted in its entirety.

Schedule 4, subsection 2(2.1), amending section 5 of the Regulated Health Professions Act, states, "If the minister requires a council to provide reports and information to the minister, the minister may require that the reports and information contain personal information and personal health information about any member of the college...." We submit that physicians have the same right to privacy and protection of their personal health information as any other patient. This section should be redacted in its entirety. It is also unclear what the minister would do with the information that they collected and whether that, too, would become a matter of public record.

Schedule 4, subsection 12(2), paragraphs 8 and 9 state that the public register will contain "a notation of every matter that has been referred by the Inquiries, Complaints and Reports Committee to the Discipline Committee under section 26 and that has not been finally resolved, including the date of the referral and the status of the hearing" etc. Publicly disclosing unproven allegations is prejudicial to physicians and contrary to the public interest and violates physicians' rights to procedural fairness.

We hope that the committee will give serious thought to rescinding or amending these problematic sections of this act. Thank you.

The Chair (Mr. Monte McNaughton): Thank you very much. Questions will begin with the government and Mr. Fraser.

Mr. John Fraser: Thank you very much for being here today and for your presentation. As you can see, there's a need—as we heard from some of our previous delegations—to strike a balance, because there was an imbalance there or, at least, a perception of an imbalance that existed inside the public.

I take to heart some of the concerns that you've expressed here, but I want to speak specifically about immunization. We had a great presentation this morning with regard to immunization and some of the concerns that exist in the community, where people aren't getting the right information.

We know that vaccinations right now—I don't want to say they're under threat, but maybe that's the best way for me to put it right now. We do have innovation—things like immunize.ca, where parents can obtain that information.

I think it's important for the person who is delivering that service to indicate that they've delivered that service. I just think that's the best point to do it. I understand it is an added thing that people need to do, but I think that's the best way to ensure that you've got accuracy and a system you can trust. I know that you'll report if you vaccinate a child or an adult. I'm not sure that a parent will do that, and I'm not sure that they will do that if they object. Immunization is critical to public health. So I would ask you to consider that.

I understand what you're saying, but I think if we want to have something that's going to work, we have to have things like immunize.ca to provide those tools for you that make it easier than a yellow card. But also, I think it's most appropriate with the physician or the practitioner who is delivering that service.

Thank you very much for your presentation.

The Chair (Mr. Monte McNaughton): No further questions? We'll move to the official opposition and Ms. Scott.

Ms. Laurie Scott: As the previous member was mentioning, we're trying to hit the right balance with doctors. You made some very strong points about publicly disclosing unproven allegations.

The College of Physicians and Surgeons was just before you. Did you get a chance to hear what they said, that they act immediately?

Dr. Sharadindu Rai: Yes.

Ms. Laurie Scott: Can you comment on their comment, if you don't mind—when they say that they intervene immediately? Do you know, in your practice—I'm asking you as a physician.

Dr. Sharadindu Rai: I think the College of Physicians and Surgeons of Ontario does an excellent job of managing these complaints of sexual abuse.

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I can also tell you that in the most recent issue of the Dialogue, which is the publication put out by the CPSO, there was a complaint that went to discipline of it. Again, it was sexual in nature, and those allegations were ultimately proven to be untrue.

The college, naturally, is trying to protect the public interest, so I fully expect them to do what they're doing. But from a physician's perspective, it's patently unfair, if those allegations are ultimately proven to be untrue, for those allegations to be on the public record forever.

I think we have to consider what kind of impact that has on the average clinician in the province who is performing intimate exams, medically indicated. They may have, in their routine medical practice, some very serious concerns that the patient in front of them will indeed make an allegation that is patently false. It's going to go to discipline, and then that allegation will ultimately be published, even though it's patently false.

That is our big concern with this. It fundamentally violates our rights to procedural fairness and also to the privacy of our own personal health information. There are 30,000 physicians in Ontario. We should have the same expectation of the privacy of our own personal health information as anyone else. For the college to disclose that to the minister on request seems a bit of a reach.

Ms. Laurie Scott: Okay. Thank you very much for your presentation.

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

M^{me} France Gélinas: It's a pleasure to see you. Thank you for coming to Queen's Park.

The first part about vaccinations: I couldn't agree more. We spent billions of dollars on eHealth. You have to enter this information into your health record. Why doesn't it automatically populate the database of the public health units? I don't know why we cannot get that right, but it would certainly make life a whole lot easier for a whole lot of people that, as you enter the data into your own health record, it gets shared. End of story; it's done. I fully agree with you: Let's get the app out as fast as possible and move on with this.

I have no hope, no hope at all, that this will come. In the meantime, we'll have to find something to bridge that gap, because Ontario is not moving in that direction. We're actually moving in the opposite direction.

I didn't mean to burst your bubble, but this is the way it goes.

Second, the personal information: What would reassure you? I have an extreme problem with that too. I don't want anybody to have access to personal health information. I talked against this in the Patients First bill. I didn't like it; I don't like it in this bill either. What would reassure you? Is there any reason whatsoever that would ever justify the ministry getting access to your personal information at CPSO?

Dr. Sharadindu Rai: Again, I think the college does an excellent job of prosecuting such and similar cases. To my knowledge, I cannot recall reading in the Dialogue of a single instance in which the minister required that information for the purpose of protecting Ontario's patients from sexual abuse. To my mind, the rationale for it (a) is unclear, (b) what the minister will do with that information is unclear, and (c) I think that part of the bill should either be redacted or very strict prohibitions be placed on the minister that they will not publicly disclose that information.

With regard to vaccinations, I'd also add that it's not unusual for my patients to go to other countries—for example, China—and get vaccinations there. Putting the onus on me to report the vaccination to the health unit does not do my patient any favour when they travel outside the jurisdiction of Ontario. What we really need is that harmonized online e-portal, where it's actually the patient who is reporting their own vaccination as they receive it. That's why I'm saying that that burden should not be falling on us.

The Chair (Mr. Monte McNaughton): Thank you, Doctor. That's all the time today. Thanks for your presentation.

DR. RAMONA COELHO

The Chair (Mr. Monte McNaughton): We now have, via teleconference, Dr. Coelho. Dr. Coelho, are you on the phone?

Dr. Ramona Coelho: I am on the phone.

The Chair (Mr. Monte McNaughton): Did I pronounce your name correctly?

Dr. Ramona Coelho: It's okay. It's Coelho.

The Chair (Mr. Monte McNaughton): Coelho? Okay. Thank you. It's MPP McNaughton, the Chair.

You'll have six minutes for your presentation, followed by three minutes of questioning from each party, beginning with the official opposition. If you'd state your name and begin with your presentation, that would be great.

Dr. Ramona Coelho: Okay. My name is Dr. Ramona Coelho and I have worked for over five years at McGill University in Montreal, with half-time care for the disabled and dying and regular clinic, while supervising students, residents and IMGs. In London, Ontario, for the past five years, I have had a family medicine practice, mostly made up of patients suffering with chronic pain, mental illness, and refugees and immigrants. A large part of my extra time is spent mentoring students and residents. My husband, Dr. Philippe Violette, is a clinical epidemiologist and urologist. He spends his free time devoted to very high quality research on an international and national level.

I am also a member of Concerned Ontario Doctors and a newly elected member of OMA council.

Coming from McGill, I am proud to say that there is a strong history of professionalism, for which Drs. Richard and Sylvia Cruess are well known. Professionalism is the basis of the patient-physician trust. Medicine will always remain a moral endeavour that requires integrity, competence and high ethical standards in order to best serve our patients and society.

The professional attributes lived by the physician will not only greatly benefit patients but, over time, for the physician who continues to transform themselves, they can become a highly principled individual.

Bill 87 might be an attempt to deal with sexual abuse, but the bill overshoots the boundaries of fairness and charter rights of physicians, as well as the false regulation of the profession. When these pillars of professionalism are undermined, it threatens the delivery of excellent patient care.

One way this bill fails to see how professionalism works is the following: Bill 87 discusses adding licences for collecting medical specimens as well as physicians now having to report patient vaccines to the local authority. Collecting specimens is a service offered for the convenience of the patient. I am not remunerated for strep cultures or urine samples collected and submitted to laboratories. Licensing will make specimen collection more difficult and, therefore, less likely to be offered to the patient from the office.

The same is true for vaccines. The remuneration is not proportional to the time and monitoring it takes, but it is professional to offer this to increase the likelihood that parents will vaccinate their children.

I do many unremunerated tasks daily. I go through paperwork, contact specialists, and follow-up labs and diagnostic imaging. I also review consults that come back to me and follow the recommendations made. In fairness, these decisions to add burdens to our unpaid tasks should have been discussed with the OMA and front-line physicians. The ministry, which has failed to create a centralized electronic immunization registry and also has not helped us find a contract with physicians, now feels they can add to our unpaid workload.

Secondly, the bill has problems with privacy and undermines basic protections for the physician. The bill is vague in allowing the Minister of Health access to the personal info and health info of physicians without clear specifications, and that it will only be done if necessary. Which physician feels protected with such vague specifications to access our personal and health information?

Also troubling in regard to the right of privacy is that the patient's complaint will be posted publicly, with the possibility of a licence being revoked, all before the fair exploration of evidence from both parties. These new specifications will only force physicians to act in a defensive, rather than professional, manner.

Professionalism entails self-giving, but, as I said earlier, it requires trust from society. When the government puts physicians' reputation and security in unfair peril, you will find it harder to draw professionalism from doctors. Many physicians have already told me that they no longer feel comfortable doing breast, Pap and pelvic exams. Some doctors have even mentioned not accepting difficult patients who are perceived to make unfounded complaints.

This is not good for society, but it is an understandable reaction, given the situation. If doctors are thrown in the limelight and the proper process that usually applies to every other citizen is lost, it will increase the likelihood of mental health crises and this kind of defensive behaviour. We do, as doctors, put ourselves at risk for patients' benefit, and so we open ourselves up to allegations as such. Can you imagine if an unfair complaint was made about you, posted publicly, and your job and livelihood stripped from you before you had a trial? Why would we make this the rule?

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Finally, one of the cornerstones of professionalism is self-regulation. If the Minister of Health can now appoint his own candidates to the CPSO committees and panels, this opens a door for bias and unfair regulation. It also begs whether the committees and panels will have enough physician representation. As well, this ties the CPSO and MOH even more closely together, and blurs a relationship that should be distinct, for protection of both patient and physician alike.

I strongly ask you to rethink how you approach the treatment of physicians. The history of professionalism in medicine has led to amazing patient care, and it is a higher standard than any policy or rule can hold our medical profession to.

Thank you.

The Chair (Mr. Monte McNaughton): Great. Thank you very much. We'll move to the official opposition for questions: Ms. Scott.

Ms. Laurie Scott: Thank you very much. You made some very poignant points—I know Concerned Ontario Doctors is your group—that we heard from other doctors, that have been brought forward.

Do you have any amendments you can send in later? Or what would you recommend for how the situations, especially for doctors accused of inappropriate behaviour—most commonly, we've heard of sexual assaults—how a process can be made better so that the public can be assured that there is this transparency? I hear what you're saying. Absolutely, allegations that aren't proven and are made public—this is obviously not a fair approach.

Dr. Ramona Coelho: I think that the OMA has proposed amendments. I haven't had a chance, in all honesty, to look at them, but I can. I'm going to send in my written submission. I can send in certain attachments of what I think is appropriate in those situations. I understand that it is a difficult situation.

Just to be very frank with you, I have had several very uncomfortable situations in my life where I've been put in those situations by the patients. They didn't make a complaint—not that I did anything, but they could have, because of how they—they didn't get what they wanted from me, so they could have made a false allegation, let's say, of a sexual nature.

I just feel there have to be adequate protections for us, because we go out there—like I said, I take care of people with very severe mental illness, people who struggle every day and might even be considered difficult by the rest of the population. But by doing that, I put myself at probably more risk than other physicians. I just feel that the rules have to be very fair. Exposing us and putting our names on a public register that stays there, without exploring the complaint first, is dangerous.

Ms. Laurie Scott: I hear you. Thank you very much for taking on the clientele that you do. It is difficult. I think my colleague—

The Chair (Mr. Monte McNaughton): Mr. Bailey, you have about 30 seconds.

Mr. Robert Bailey: Okay, I won't take long. You did refer to schedule 2. I asked some of the other presenters earlier—I had a doctor approach one of my constituents, and they were concerned that they would no longer be able to collect specimens in their practice. Can you explain, as quickly as you can, what that's about?

Dr. Ramona Coelho: My understanding is that the bill is ambiguous as to whether physicians will now have to obtain licences for collecting specimens. Some doctors even do venipuncture, which I think is a remunerated service, but I just do urine cultures, strep throats, STD testing, that kind of stuff, in my office. My understanding is that the bill is ambiguous as to who would fall under it—who would now have to start getting licences for collecting specimens, which would be problematic for us.

Mr. Robert Bailey: Okay. That's the best answer I've had so far.

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

M^me^ France Gélinas: Good afternoon, Dr. Coelho.

Dr. Ramona Coelho: Hi.

M^me^ France Gélinas: Thank you for phoning in. I too was curious about the specimen collection. The way you read it—and you are now a member of OMA as well as Concerned Ontario Doctors—you still have worries that the way the bill is written right now does not make it clear enough that physicians' offices won't have to go through the process of licensing and quality assurance and all of that. It's not clear to you?

Dr. Ramona Coelho: No, and I'm not a lawyer. I did read over the bill, but even OMA's legal analysts weren't sure of where it sits for physicians in terms of collecting. Even for someone who understands legal writing, the bill is ambiguous on that point, and on many points. I think that that's the main problem with this bill.

M^me^ France Gélinas: Have you reached out to the ministry to try to have it clarified, and what was their answer?

Dr. Ramona Coelho: Sorry? Did I reach out to the ministry on this issue?

M^me^ France Gélinas: Yes, did you or the OMA reach out to the ministry to try to clarify the issue of whether you will become a specimen collection area or not?

Dr. Ramona Coelho: My understanding, as I've last heard from the OMA, is that we are not sure of what it implies. What the OMA has done themselves—I was just newly elected; I am going to the May council. I could not say that I am representing the OMA, but I, myself, no.

M^me^ France Gélinas: Okay. But, as far as you know, it hasn't been clarified by the ministry that, no, it's clear, that's not their intent.

Dr. Ramona Coelho: No, and we've been making a lot of noise about Bill 87. If they wanted to clarify it, I feel like they could have by now.

M^me^ France Gélinas: Agreed. You have been making noise, as you say. I see you on my Twitter account—many, many every night.

The second thing is you feel that, right now, if we pass Bill 87, the CPSO will have too much power to take away licences without due process. But at the same time I will tell you that what we have now doesn't work. I hate to continue to read the Toronto Star, and have a full-page on the abuse of patients by physicians, where the CPSO says that we need to be able to act sooner. Where would you like this pendulum to swing to?

Dr. Ramona Coelho: Okay, so I absolutely agree. I luckily do not read Dialogue every month—I try not to read it. But professionalism, where it fails, needs rules. What I was saying is that, in our medical schools, in the

way that we deal with patients, the way that we mentor our students, we need to—

The Chair (Mr. Monte McNaughton): Doctor, that's all the time we have for the third party.

Dr. Ramona Coelho: Oh, I'm sorry.

The Chair (Mr. Monte McNaughton): No, that's okay. We'll move now to the government and Ms. Wong.

Ms. Soo Wong: Thank you very much, Doctor, for joining us this afternoon.

Dr. Ramona Coelho: You're welcome.

Ms. Soo Wong: With regard to Bill 87, can you share with us how the proposed amendments will improve patient care, specifically patient safety, and the integrity of your profession?

Dr. Ramona Coelho: Sorry, Ms. Wong, I don't know if you heard me answering the Conservatives, but I said I have not read the OMA amendments.

Ms. Soo Wong: No, I'm not asking about the OMA. I'm asking, in your opinion, as a witness for this committee, I'm not asking for the other professional body. You, as a physician, are coming before this committee. I want your opinion, as Ontarians participating in this conversation, in regard to the proposed amendments that are being put forth, how do you ensure—because you do have patients. You told us that you are a practising physician. How do you see these amendments being proposed by the government improve patient safety and, more importantly, the integrity of your profession?

Dr. Ramona Coelho: I'm sorry, I'm sure there's a miscommunication here, but I have not read the amendments. I can't comment on amendments I haven't read.

Ms. Soo Wong: Okay. Thank you.

The Chair (Mr. Monte McNaughton): Any further questions from the government? Okay. Thank you, Doctor, very much for your presentation today.

Dr. Ramona Coelho: Thank you very much. Have a nice day.

The Chair (Mr. Monte McNaughton): The committee will be meeting next Wednesday at 12:30 on May 3, 2017.

I should have started by thanking Valerie for filling in over the next few weeks while Will is off.

We'll see you next Wednesday.

The committee adjourned at 1449.

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