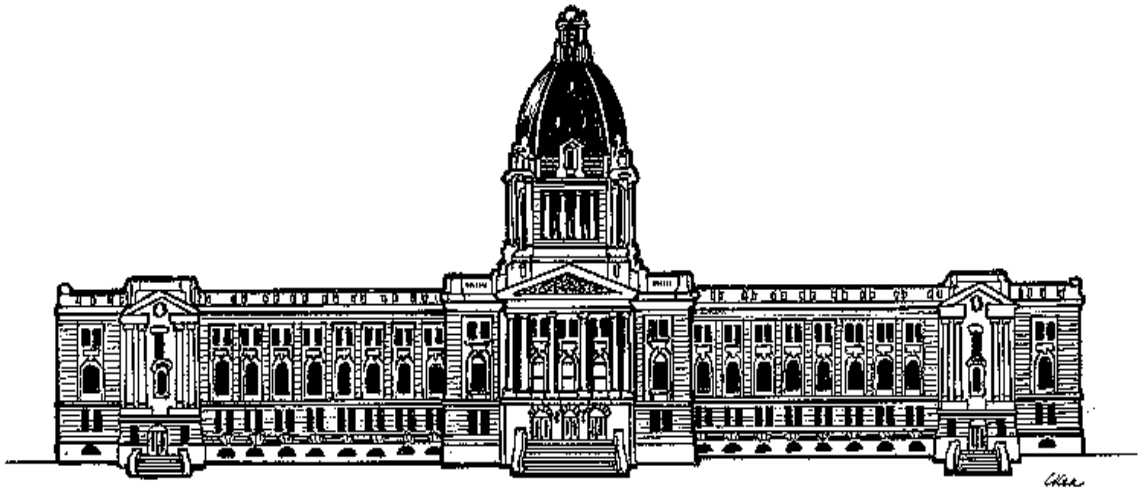
STANDING COMMITTEE ON INTERGOVERNMENTAL AFFAIRS AND INFRASTRUCTURE

Hansard Verbatim Report

No. 34 — February 5, 2007



Legislative Assembly of Saskatchewan

Twenty-fifth Legislature

STANDING COMMITTEE ON INTERGOVERNMENTAL AFFAIRS AND INFRASTRUCTURE
2007

Mr. Ron Harper, Chair
Regina Northeast

Ms. June Draude, Deputy Chair
Kelvington-Wadena

Mr. Denis Allchurch
Rosthern-Shellbrook

Mr. D.F. (Yogi) Huyghebaert
Wood River

Mr. Andy Iwanchuk
Saskatoon Fairview

Hon. Len Taylor
The Battlefords

Mr. Kim Trew
Regina Coronation Park

Published under the authority of The Honourable P. Myron Kowalsky, Speaker

[The committee met at 13:00.]

Bill No. 20 — The Gunshot and Stab Wounds Mandatory Reporting Act

The Chair: — Good afternoon, ladies and gentlemen. I would like to convene the committee for the Standing Committee of Intergovernmental Affairs and Infrastructure. The business before the committee here today is to deal with the consideration, I guess you'd say, given to Bill No. 20, The Gunshot and Stab Wounds Mandatory Reporting Act.

We have this afternoon a number of witnesses coming forward. I would like to remind the witnesses that a maximum of 20 minutes is allocated for your presentation. That will be followed with a maximum of 30 minutes for question and answers. Now in the event your presentation doesn't go the full 20 minutes, the additional time will be used for question and answers.

So with that I will ask the minister, who is our first witness before this committee, to introduce himself and his officials.

Hon. Mr. Quennell: — Thank you, Chair. Frank Quennell, Minister of Justice and Attorney General, and with me today is Mr. Darcy McGovern, Crown counsel of legislative services.

I thank the committee members for this opportunity to further explain the purpose and scope of this important legislation through what I understand to be the first of such public hearings at this more advanced stage of proceedings for a Bill in the Saskatchewan legislature.

Like you, I look forward to hearing the position of the witnesses and to the opportunity to address any questions or concerns which that testimony may raise for the committee at a subsequent date.

This government has, over the past several sessions, demonstrated its commitment to using its civil jurisdiction to provide tools with which to build safer communities in which Saskatchewan families can live, work, and build strong futures. We have already introduced legislation such as The Safer Communities and Neighbourhoods Act, The Criminal Enterprise Suppression Act, The Seizure of Criminal Property Act towards this end.

The Gunshot and Stab Wounds Mandatory Reporting Act reaffirms this commitment to community safety and crime prevention by establishing a new and simple notification procedure of compulsory reporting by hospitals of gunshots and stab wounds to local police services.

The reporting under this Bill will occur by telephone and will occur as soon as possible after the hospital has received a patient who has been a victim of a stab wound or a gunshot wound, as long as it does not interfere with that patient's treatment. This reporting will be the legal responsibility of the hospital. And the notification will be strictly limited to the identification of the patient, the fact that they have suffered a stab wound or a gunshot wound, and the location of the hospital facility where they have been treated. No further personal medical information will be disclosed through this process.

This strikes an appropriate balance between the important privacy rights of patients and the need for public safety, including the protection of both our citizens and our front-line medical service providers.

For this reason, the Bill addresses only the immediate information necessary for the police to commence an effective investigation. For example, the past medical history of an individual will never become subject to disclosure under this Bill. This legislation was requested by the Saskatchewan Association of Chiefs of Police as a tool that will allow them to work with front-line health service providers to help improve public safety.

Existing access and privacy information has long permitted the disclosure of this type of information, but the lack of specificity as to when and how this would occur has created uncertainty among health providers and police services. This Bill will provide for much greater clarity in this regard.

In our discussions with representatives of the regional health authorities, the Saskatchewan Medical Association, and the College of Physicians and Surgeons, it was recognized that in the extreme circumstances of gunshot or stab wounds it was appropriate that the police be notified. This limited disclosure of personal information will allow police services to learn of and investigate violent acts in our communities, and to ensure that this community violence does not continue to place people at risk and does not follow the patient into that hospital during or after treatment.

Saskatchewan will be the second province in Canada to introduce this type of legislation and the first to apply it to stab wounds. Ongoing consultations with the police community and health care service providers will allow us to refine through regulation in what circumstances a stab wound will properly require reporting under this legislation. For example, accidental self-inflicted stab wounds may well be excluded from reporting under the regulations to this Bill. Our intention is to address only those stab wounds that occur through an act of violence, and we will be carefully ensuring that this is the result.

Members of this committee will be aware that there have been concerns raised regarding the intended operation of this Bill. The Information and Privacy Commissioner has questioned not only the privacy implications of this Bill but has also questioned the jurisdictional capacity of the Legislative Assembly to even address this issue.

For the record, I can advise this committee that on December 5, 2006, I responded to the letter tabled in this Assembly by Mr. Dickson as follows:

> It is clear from your letters that you disagree with the policy choice made in this Bill to disclose a very limited amount of personal health information to a local police service, in order to facilitate crime prevention and promote public safety. Under the Bill, it is only the name of the individual, the fact of the stab wound or the gunshot occurring and the location of the hospital that will be subject to disclosure.

> This government is committed to the protection of personal information held on behalf of our citizens whether in the health sector, or in other government sectors. I remain of the view that the very limited information which is mandated for disclosure under Bill 20 is an appropriate and justifiable balance between the need for the protection of personal health information and the need for the promotion of public safety and crime prevention. I am confident that the Legislative Assembly and the Saskatchewan public will also support this approach.
>
> With respect to the constitutionality of the proposed legislation, please be assured that as Attorney General and Minister of Justice, I take very seriously my responsibility to ensure that all government legislation presented to the Legislative Assembly is constitutional in all respects. The advice I've received from my constitutional law experts in the Department is that this Bill is within the provincial legislative jurisdiction and comports with the *Charter*. Without going into detail, I would note that:
>
> > the purpose of the Bill is not punishment. The Bill is focussed on the receipt of information from the victim of a gunshot or stab wound to enable the police to prevent further crimes if possible; indeed there is no offence provision included in the Bill;
> >
> > it is well established that the suppression of conditions likely to favour the commission of crimes falls within provincial competence;
> >
> > the disclosure of information under *The Freedom of Information and Protection of Privacy Act*, *The Local Authority Freedom of Information and Protection of Privacy Act* and *The Health Information Protection Act* (or similar legislation in other provinces) to third parties, including police services for specifically stated purposes has long been recognized as a legitimate exercise of provincial powers [as a local matter and] as a matter of property and civil rights; and,
> >
> > the very limited amount of information permitted to be provided is both reasonable as an important method to avoid further similar occurrences and proportional to the public safety risk and need for crime prevention that gunshot and stab wounds represent in our community, particularly as this is civil rather than criminal legislation.

I will table this letter with the committee and the balance of it can be reviewed by members if they so choose.

I have not subsequently heard from Mr. Dickson on this matter, so I am not clear whether his concerns will be focused on debating the privacy versus public safety policy choice made in this legislation or that the broader legal issues will remain.

We continue to be of the view that this Bill is within the province's jurisdiction and that it complies with the Charter.

I will turn then to what I believe to be the core policy issue that is raised by the Information and Privacy Commissioner: is the notification of police of the fact that there has been a gunshot or stab wound victim, the name of the victim, and the name of the hospital, an unreasonable incursion on that victim's privacy? In my view that is the legitimate policy choice that this committee is being asked to consider. This government remains committed to promoting community safety, to combating violence, and to striking an appropriate balance between disclosure of information in the public interest and the protection of privacy.

The Health Information Protection Act appropriately goes to great lengths to protect the personal health information of every Saskatchewan citizen. That is why the Assembly passed this important privacy legislation and why all the personal health information of the patient, other than the name and fact of the wound occurring, will remain carefully subject to the requirements of that Act.

The Bill authorizes only the simple notification in this overtly dangerous circumstance. The Bill does not and will not authorize incursions into more detailed health histories of any individual. Any suggestion that it will is simply not accurate. Any concern that it will is misplaced.

Saskatchewan was the first province in Canada to introduce The Victims of Domestic Violence Act. And this legislation has since been adopted in a number of other jurisdictions in an effort to recognize that family violence is a public offence, not a private matter. We have learned in this context and in the context of mandatory reporting of child abuse that silence and intimidation are the tools of the abuser. It is incumbent upon lawmakers to provide the legal support necessary to show that.

Just as it is not a matter of personal choice whether to report child abuse, it should not be a matter of personal choice to decide if gunshot or knife wounds are a threat to public safety. It should not be the choice of the victim who is suffering the abuse and who may be understandably intimidated and abused, and it should not be the choice of the individual caregiver who may not be able to readily assess the danger to or even from that individual upon their release.

In Canada the victim of a crime does not make the decision of whether charges should be brought forward. That is a societal decision made in the public interest. There is no room in a just society for crimes of acquiescence. We have long ago recognized that even a consensual gun or knife fight is a public crime. The combatant victim does not get to choose whether the charges will be brought forward.

Unfortunately some of us are apparently still struggling to recognize that domestic abuse is a public crime and that the cycle of violence and remorse in these relationships requires intervention and recognition of the crime that such abuse represents.

Requiring a hospital to notify the police of a violent incident that is an inherent threat to public safety is a legitimate and appropriate policy decision for Saskatchewan lawmakers to make. By all means education and social assistance efforts must also continue and improve. But in my view, this province can and should do both.

It can address immediate public safety while seeking to address root causes for community violence. And it can do these things with only the most limited incursion on personal privacy — the name of the individual, the fact they've suffered a gunshot or stab wound, and the name of the hospital where they are being treated. Nothing more is being asked, but certainly nothing less should be required.

To provide one example, perpetrators of domestic violence can only be provided with the option of programming through the domestic violence courts if they come before those courts. And they can only come before those courts if these acts of violence are investigated by the police. And those acts of violence can only be investigated by the police if they are reported to the police.

You will be hearing from our police community that asked for this legislation. The police are confident that being told of violent incidents in our community will help them prevent their proliferation. I would ask this committee to listen carefully to their request in this regard, to their experience on Saskatchewan streets when actually reporting child abuse, and to their preference for action now rather than further study.

The Bill asks the legislature to help these people and the community at large by declaring that a decision has already been made. Guns and knives are a threat to public safety even in cases where their use is consensual. This Bill introduces the most limited of notification systems for public police agencies in these patently dangerous circumstances.

No one health care provider or police officer can be fingered as the person who notified the police. The law will require the hospital to arrange for that notification. If we as policy makers want such notification to occur whenever a gun or knife assault occurs, then it is our responsibility to make that decision here. We should not ask front line individuals to bear that burden for us, asking them to guess when to notify and what information to provide only to be criticized when they fail to notify the police or if they provide too much personal health information when they do.

Simply put, if we cannot think of a situation where the police should not be contacted in a case of a gun or knife assault, then we as elected lawmakers should make that decision here and now. We should not be off-loading those responsibilities.

The concern has also been raised that mandatory reporting will place individual health providers at risk or they will make victims reluctant to seek medical assistance. We take both of these concerns very seriously.

Fundamentally, we are strongly of the view that it will improve hospital safety to have police notified of gun and stab wound victims. By their very nature, these violent incidents may lead to recriminations and further attacks.

As with child abuse, if we make a simple notification process part of the law and, further, a responsibility of the hospital and its chief executive officer, then we take this difficult decision and any blame for its occurrence out of the hands of the individual health care worker.

I am sure that no one in this room would disagree that, privacy issues notwithstanding, health care staff are entitled to contact the police for assistance when they are personally at risk. This legislation recognizes that immediate risk where violence has already occurred and may continue. A public health care facility is not a legal sanctuary from the police and we should not delude ourselves that those who commit violence would respect it as such either.

Over 40 American states operate with mandatory reporting legislation, in addition to the province of Ontario. The available evidence simply does not support the assumption that some have made that individuals will avoid treatment because the requirements to report the results of violence have been clarified by this legislation. Indeed, the only empirical study we have located does not bear this out. Let me emphasize this point. The suggestion that wounded individuals will avoid treatment at their own peril has not been substantiated.

Seeking public health care for a gunshot or a knife wound should not carry with it an expectation that this violent act will remain secret. Indeed, we have no reason to believe that such an expectation is currently widely held.

It follows that the simple act of clarifying the obligation of hospitals to report gunshot and stab wounds should not result in a significant change in people's behaviour. Our hospitals will continue to welcome all who seek assistance, without reservation and with a uniform standard of care. This simple notification of the police seeks to ensure that fewer people will need to seek those hospital services in the future. It also seeks to ensure that those members of the public who seek those services, and those who provide them, can do so with increased safety.

Chair, where there are violent acts in our communities, it is imperative to public safety and crime prevention that police services are informed of such activities and that they are able to commence an effective investigation in order to prevent their reoccurrence. This Bill works with health service providers and our medical community to ensure that this will occur.

This is an eight-section Bill that only takes up two pages. Section 3 of the Bill sets out the requirement that police be notified of these violent acts with only the very minimum information necessary to effectively respond to this clear threat to public safety.

I would submit that the policy issue before this committee is relatively clear, and it's a choice which Saskatchewan legislators are entitled to make. I look forward to responding to any questions you may have at this point, and to responding to any further questions you may have after we have all had a chance to hear the witnesses to this committee. Thank you, and good luck in your deliberations.

The Chair: — Thank you, Mr. Minister. If you have any documents you wish to table with the committee, we would accept them now.

Hon. Mr. Quennell: — I have copies, enough for the committee, of documents referred to in my remarks and some other documents.

The Chair: — Thank you. And while those are being distributed, I was amiss on some business at the opening of the committee. We have Mr. Morgan substituting for Ms. Draude and Mr. Yates is substituting for Minister Taylor as sitting members of the committee today.

We'll now entertain the question and answer portion of our hearings, and we will start them with the opposition members. Mr. Morgan.

Mr. Morgan: — Thank you, Mr. Chair. The questions that I'm posing, I don't want the Chair or the minister to think that they are indicative of a particular direction or an agenda that we have. They're questions that have been put forward to my office by constituents and members of the public. So I'm asking the questions on their behalf rather than advocating any particular position. So I want to make that clear at the outset.

The first one is dealing with the scope of the Act. This Act deals specifically with gunshot and stab wounds only. In our province we have physical violence done to people by a number of different methods, not necessarily using a gun or something that would cause a puncture wound. In fact we have a number of instances where people are killed or badly injured where the perpetrator of the crime used nothing more than their bare hands. So the question was, would we not focus on injuries caused by a blunt instrument or caused by some other form of weapon — hammer, baseball bat — or no weapon at all? And the question was, would it not be worthwhile to consider injuries that were likely or potentially caused by a criminal or an unlawful act?

Hon. Mr. Quennell: — Yes. Thank you. I will do my best to treat the questions as genuine questions and not rhetorical questions because I don't believe that they do necessarily reflect an agenda. And I think it's useful to ask the type of questions Mr. Morgan has asked to elicit the intent and the effect of the Bill and perhaps some areas that the committee will want to explore or even make recommendations about at the end of its proceedings.

The Bill is very limited in a number of ways. It's limited in what type of information is provided. And I went into a fair amount of detail and perhaps some repetition in my remarks in that regard. Secondly, it's limited as to what the facility that's required to make a report, and that limitation in the Bill expressly is hospitals although there is the ability to expand that by regulation. And witnesses' thoughts and members of the committee's thoughts about that limitation, I think, would be useful to the government. And the other limitation, as Mr. Morgan points out, is to the type of injuries caused by violence that would be reported.

I would note again — and I appreciate the members of the committee know this — that within Canada we will be the only the second province that requires reporting of gunshot wounds. We will be the first province, the leaders, in respect to reporting of stab wounds. There are a number of those 40 American states that also require disclosure of stab wounds.

I believe currently — although I'm interested in hearing the testimony before the committee — that it is useful to begin with this limited disclosure, limited in respect to information, limited in respect to facility, and limited in respect to the type of injury caused by violence, to see how this legislation works in effect in Saskatchewan, but be open to expansion of the legislation if we believe that there would be a net benefit from doing so. So for the purposes of this Bill, we have decided to limit the scope to gunshot and stab wounds. That is because to a large extent we are — having gone as far as including stab wounds in our Bill — we are the national leaders. And we want to take this one practical, appropriate step at a time and not overreach ourselves.

We are bringing a significant change to the legislation in the province. As I said, we are national leaders at this . . . [inaudible] . . . I think Mr. Morgan's original suggestion that this legislation might be expanded to include blunt instruments and his question today are worthy of consideration. But we have made the policy choice to limit the scope of the Bill in a number of ways, in part because certainly within the country of Canada, we will be leaders as it is.

Mr. Morgan: — My next question deals with the focus on the specific type of wounds. And that doesn't exclude — unless they're excluded in the regulations — the accidental type of injury that may be caused by that.

I appreciate some of the comments that were made elsewhere that it's unlikely but possible that you would have an accidental gunshot wound, but you could certainly have an accidental stab wound.

And the one comment I had came from my spouse so to the extent that you may want to regard that one as a political agenda, feel free. She had . . . separating some steaks that were frozen together with a paring knife and stabbed her hand and I drove her to the hospital to have two or three stitches put in her hand. Under this Bill, absent regulations that would exempt that type of injury, that injury would have been a reportable injury.

Now I think she would probably be quite prepared to admit it was, I wasn't in the room when it happened. But nonetheless I guess I'm somewhat troubled that we've focused, by definition, the Bill on gunshot and stab wounds, and we've neglected to include a criteria that there be a criminal component in there or a potential that it be caused by an unlawful act. So I presume it's the position of the department that you may pass regulations that would exempt clearly accidental injuries. But I'm wondering why those wouldn't be included right in the legislation to give some additional comfort to a health care worker.

Hon. Mr. Quennell: — In part, my answer would be that if we thought that was going to be the only limitation, we might include that in the legislation. After the hearings of this committee but also further consultation between the Department of Justice, the Government of Saskatchewan, and the groups that can provide some expert advice, input into what we might do, there may be other limitations. Accidental may be one; self-inflicted may be another.

Whatever restrictions there are made on the types of wounds that need to be reported, there is going to be some judgment have to be made, particularly in the case of stab wounds as opposed to gunshot wounds.

As to whether the victim's version of how this could possibly come about is true or not, that's a judgment call that we have to leave to human beings. We'll be leaving to expert human beings — and that is human beings who are in practice of emergency medicine as nurses or doctors or whatever role — to make those calls. And in some cases, in stab wounds that's going to be a difficult call to make, and the worst-case result, I think, is that in the case of a serious stab wound there'd be a police investigation of what turns out to be an accident.

I think the police — and of course you'll be hearing from police officers — but I think the police would prefer to have stab wounds reported and occasionally be investigating what turns out to be an accident than not have them reported.

Mr. Morgan: — My third question deals with the information that is to be provided. Under the Act it includes the fact that the individual is being treated, the name of the individual, the name and location of the facility. And on the face of it that would appear to be sufficient information, but there's nothing in the Bill that would preclude the police from attempting to seek as part of an investigation, obtain a search warrant to obtain other health information that would be in that person's file from when they arrived.

And maybe it's dealt with otherwise, but, you know, it talks about other prescribed information. So I don't know, you know, what other . . . I guess where I'm going with this is, is the fact that this happened, where else might the police officers want to go with it, and what safeguard is there on the part of the institution that would make the report that would give them some element of protection otherwise? And I'm not advocating that there should be or should not be.

It talks about other prescribed information. I don't know what other information might be prescribed in the regulations, and I don't know what that might be for a starting point. I mean, is it fair? And if I was a police officer I'd certainly want to ask the question when I came there, did the person arrive with somebody else? How did they get here? Did they come in under their own steam? Is this the clothes that they were wearing? You know, the variety of questions that, you know, any investigator might want to inquire about.

Hon. Mr. Quennell: — Well section 4 of the proposed Bill says that:

> Nothing in this Act prevents a hospital or facility from disclosing information to a local police service that the hospital or facility, as the case may be, is otherwise by law permitted or authorized to disclose.

Mr. Morgan: — They'd get a search warrant and the information becomes . . .

Hon. Mr. Quennell: — If other legislation provides for that information to be provided, then this Act doesn't limit the effect of any other legislation. What this does do is provide clarity for the hospitals. The current situation — and I'm sorry I can't quote the exact wording — but the current information allows for hospitals to provide information to the police where they believe that circumstances are dangerous or that there's a risk to public safety. That's a pretty broad provision and I think isn't very clear in certain circumstances to individual health workers and hospitals as to whether they should provide the information or not.

We are not going to be changing that current circumstance in respect to the discretionary ability to assist the police where it would remove danger or increase public safety. What this legislation does — and the only thing it does — is say, where there has been a gunshot or a stabbing, then you must report it. So there may be other circumstances where you may report and you may provide information under the authority provided by other legislation in respect to health information. But in respect to gunshot and stab wounds, there is no discretion. I think that will be welcomed by many people in the health care field as well as by police.

And I would refer you to a letter from an emergency nurses' organization that has been tabled with the committee. The letter is mistaken in a couple of respects. One of them is that it's addressed to the Minister of Health, who's given credit for introducing this legislation when in fact the credit goes to the Minister of Justice in this particular circumstance.

Secondly, the letter was written under the assumption that having introduced the legislation, we've passed the legislation. And of course we haven't done that yet.

The National Emergency Nurses' Affiliation Inc. is extremely, as I read this letter, supportive of the legislation. It makes the important connection, I think, between mandatory reporting of child abuse and the mandatory reporting that we are suggesting. It comments on their responsibility to maintain confidentiality of patients' rights but comes to the conclusion that public safety is a priority in respect to the legislation that's being proposed. And it ends this way:

> While it should be recognized that the role of the Emergency Nurse would be solely to inform law enforcement agencies, N.E.N.A. recommends that all Canadians should be advised of this important legislation. The National Emergency Nurses' Affiliation commends the Saskatchewan government on . . . [the] responsible actions.

That's in reference to this legislation.

I need to add in addition to that comment is that we do not necessarily see it as the responsibility of the nurse to be making this report. Many hospitals have security in the hospital. I think it is reasonable to assume that in many cases that security is located close to the emergency room and that there are people whose job is the security of the hospital, who might be targeted or tasked with making the report required under this legislation. That said, the organization of nurses who work in particular in emergency rooms is supportive of the legislation.

This is an unsolicited letter. If it had been a solicited letter, it would have been giving the credit to the correct minister.

The Chair: — Thank you, Minister. Questions? We'll go to the government members. Mr. Trew.

Mr. Trew: — Thank you, Mr. Chairman. Minister, welcome to

the committee — and what a historic time. I want to address my question around health care providers that health . . . There's no doubt health care providers — whether they be nurses, doctors, or other health professionals — their job is to provide health care, not be deputies or, you know, associates of the police. I don't mean that their job is to put up roadblocks. But their job is primarily, what they're hired for and paid for and what we expect of them is to take care of the gunshot wound or the stab wound or the blunt instrument wound or, you know, whatever.

Is this Bill making health professionals sort of associates of the police? Is it making them part of the justice system as opposed to part of the health care system?

Hon. Mr. Quennell: — I would begin answering that question by saying that the primary purpose of health care providers is, as Mr. Trew says, to improve the health particularly of patients who are presented to them. And I would add that the primary purpose of our teachers is to educate our children. That said, we expect health care providers and teachers to report child abuse. That does not make them agents of the police.

Secondly, the current circumstance under The Health Information Protection Act does provide for disclosure of information at the discretion of the health information trustee on a case-by-case basis where the trustee is of the view that there is a danger to a member of the public.

Now many people I believe are currently under the misapprehension that if someone presented at an emergency room in Saskatchewan with a gunshot wound or a stab wound caused by violence, that that would automatically be reported. And to a certain extent this legislation only makes a reality of what I think are many people's expectations of our health care system — that it act to protect the health of members of the public by reducing violence and the recurring cycle of violence in certain circumstances. This can certainly be done on a discretionary basis and it might still be done in cases where there have not been a gunshot or stab wound, but we believe it certainly should be done when there is a gunshot or a stab wound.

I referred to recurring cycles of violence and prevention of violence more than once in my remarks and my answers to the questions. And some might ask, how you can prevent a violent act that's already taken place? And I think this is an issue that may be raised with the police as well and their answer may be different. But my answer is this: that in the case of violence by gangs or organized crime, that to allow violence to go unreported and uninvestigated may lead to self-help, if I can use that phrase, and other victims coming in to the hospital because they are victims of retaliation of violence that should have been reported to the police and investigated. That violence could be prevented by this legislation in some circumstances.

Much domestic violence is not a one-time event. And as I said in my remarks, if we looked towards the success of our domestic violence courts and their programming, they can only be successful if abusers and chronic abusers come before those courts. They can only come before those courts if they're brought before those courts by the police. And the police can only investigate those crimes if those crimes are reported and stopped before they happen again and again — and certainly stopped when they have escalated to the point where a weapon such as a knife is being used.

Mr. Trew: — Thank you.

The Chair: — Thank you. Mr. Iwanchuk.

Mr. Iwanchuk: — Yes. You had mentioned the present voluntary system. I was just wondering in terms of Mr. Morgan's questions, what would some of the ramifications around privacy issues be now under the present system?

Hon. Mr. Quennell: — We recognize in our legislation, our current legislation, that privacy in the case of public safety or danger to the public is not paramount. And we authorize, through the law, health care providers to provide information to the police in face of those dangerous circumstances or to protect public safety.

Certainly the province has the right and the jurisdiction to have brought in The Health Information Protection Act which provides for those exceptions which we are clarifying in the case of certain types of injuries. And certainly we had the right jurisdictionally as a province to bring in The Health Information Protection Act. And certainly we had the right under the Charter to bring in The Health Information Protection Act. I do not believe that the discretion of health care providers to provide information to the police where it's in the interests of public safety is unconstitutional. And therefore I do not believe that our clarification in respect to gunshot and stab wounds is unconstitutional.

The Chair: — Mr. Yates.

Mr. Yates: — Thank you very much, Mr. Chair. My question goes to the issue of reporting of these types of gunshots and stab wounds in communities where there may not be a hospital in fact. I had the opportunity to tour a number of northern communities this past summer. And in communities like Sandy Bay, Buffalo Narrows, and others, those communities are served by health care centres, and they're the primary health facility covering those communities and surrounding areas. I do know the legislation says both hospitals and facilities. Would it be our intent to define in the regulations that these facilities also be required to report these types of occurrences?

Because in my deliberations in meeting with communities in the North, they were looking for tools to help them deal with, particularly, young individuals that are involved in gang activities, even in small communities like Sandy Bay and Buffalo Narrows. In communities like Sandy Bay, Pelican Narrows, and others I visited in the North, gang activity was very prevalent. It started perhaps much younger even than in some of our larger urban areas. And both the police and the community were asking for tools to help them deal with these individuals.

Hon. Mr. Quennell: — Mr. Yates makes a good point that neither gang violence or domestic violence are limited to large urban centres where there are hospitals. I am, as I said, very interested in hearing — probably reading — the testimony of all the witnesses before this committee in respect to this legislation. And we will be having further consultations about

what information, not necessarily what more information about patients can be provided, but what more information in respect to other injuries — burns, bruising caused by blunt instruments — might be provided and consultations about what other facilities might be included.

We believe that it would be effective — and I take some comfort from the request that was made by the police chiefs in this respect — to require reporting of gunshot and stab wounds of victims who present themselves to emergency rooms. As I've said, we would be open to expanding that. But we were unwilling to start with every health facility, including a doctor's office, as a facility that would be required to make this reporting — particularly if what we are doing is taking, I think, a reasonable first step in this respect, and again as I said, to a large extent leaders in this country on this step.

If it is demonstrated that people's behaviour changes, then we may want to make changes in respect to the facilities. We may want to make changes in respect to facilities even if people, when they sustain such a major injury, continue to go to emergency rooms as I expect will be the case. I don't expect this legislation will change people's behaviour.

We may very carefully want to look at the issue of communities that don't have hospitals and how the facilities where people receive emergency treatment can be designated under this legislation without necessarily casting a wider net than we intend or need.

The Chair: — The next question goes to the opposition. Mr. Morgan.

Mr. Morgan: — My question is actually almost identical to the one posed by Mr. Yates. And the situation that I was asking about was a situation where a person was transported some distance, specifically brought to Saskatoon or Prince Albert by air ambulance. They don't actually get to a facility within the meaning of the regulation until sometime later on.

They're treated, you know, with whatever interim . . . [inaudible] . . . The first time they're at a hospital or facility is after they've been transported some distance. So the police, to have any benefit from the legislation at that point, would have no sense of where the person was injured or anything else.

So my question is, has there been consideration — and maybe you've answered the question already — to air ambulance, to EMTs [emergency medical technician], to ambulance drivers, or other people that may reasonably come into contact? And specifically where there's a long distance, but even in places just within Saskatoon, would it not make sense to give some protection to those people as well or have those people as well notify the police of the first incidence, particularly if they've moved somebody from a location where a violent crime has occurred, where there may be blood spatters or whatever other things that may be of some significant benefit or significant interest to the investigating officer?

So anyway, I'm not at this point advocating that the Act be enlarged, but those are sort of the shortfalls that have been put forward as being potentials.

Hon. Mr. Quennell: — The hospital that treats an individual who has received a gunshot wound or a stab wound is required to report. So for that part of the question it doesn't matter whether I'm attacked across the street from a hospital or 150 miles away from the hospital. Upon being treated at a hospital, the hospital has the obligation. Now where an individual reports a crime many, many miles away from where the crime was committed, that poses difficulties for police in all those circumstances and they also would exist in this particular case.

But the question is whether we would get early reporting and therefore more timely investigation by the police by requiring the reporting be made, not by the hospital, but by the first responder, emergency responder. I note that the paramedics are testifying before the, or their association is testifying before the committee today. So I'm not going to tell Mr. Morgan what questions to ask, but that might be a question put to them.

The government has made the decision not to place this obligation upon nurses or doctors or paramedics, but to place it upon the institution of the hospital — partly to protect those individuals and to distance them from this, what some people see as a dangerous decision to make. To put this obligation onto paramedics might be more convenient for the police but we've decided not to place this obligation to report upon one of the health professions or any of the health professions in particular, but upon the institution.

That's, I think, a live issue to discuss. I believe that the registered nurses, through the media and to a certain extent the Privacy Commissioner, have raised reasons why we might not want to put this obligation on members of the health professions.

The Chair: — Mr. Yates. Mr. Yates, we're getting close to the conclusion of our time so if you wouldn't mind putting your question as directly as possible.

Mr. Yates: — I will. Thank you very much, Mr. Chair. My question is, I would like clarification on today under the HIPA [The Health Information Protection Act] regulations as they exist, this information being asked for in this Bill could be provided. The only difference is that in this case it is now mandatory to provide this information. Is that correct?

Hon. Mr. Quennell: — I know the Chair's comments are about questions but I'll also try to make my answers as direct as I can too. Section 27(4)(a) of The Health Information Protection Act provides:

> A trustee may disclose personal health information in the custody or control of the trustee without the consent of the subject individual in the following cases:

And this is (a):

> where the trustee believes, on reasonable grounds, that the disclosure will avoid or minimize a danger to the health or safety of any person;

So that's the wide discretion that already takes place. We are not limiting that discretion. That discretion will still be there. But we are saying that in the case of a gunshot or stab wound,

through this Bill that may becomes a shall.

Mr. Yates: — Thank you very much.

The Chair: — I'll give the last question to the opposition. Mr. Morgan.

Mr. Morgan: — The Act does not define the term stab wound and there may be that there's a medical definition of stab wound that I'm not aware of. But I'm wondering how you differentiate between an injury that breaks the skin by a cut or an automobile accident as opposed to a puncture-type wound and maybe there's a medical answer to that. I don't know. I notice it's not in the Act so I'm assuming that it's maybe dealt with either by medical jargon or something.

Hon. Mr. Quennell: — Well again we will be hearing from both the Saskatchewan Medical Association and the College of Physicians and Surgeons. They can probably be more helpful than I can be. My expectation is — but I stand to be corrected — that there is a limited degree to which we can be precise in distinguishing a stab wound that would be caught by the Act and a cut as previously described by Mr. Morgan that was accidentally received in the kitchen. I wouldn't want, for example, to limit our definition of stab wounds to punctures. The defensive wounds of a spouse defending herself against domestic abuse may result in more like cuts or slashes on their hands than puncture wounds. And I suppose more than one slash across one's hand might be a good indication that it wasn't accidental.

But those are the kind of judgments that have to be made by health professionals and have to be made by police. And to a certain extent you're always relying in these cases on people's expertise and the proper exercise of their judgment. But again you'll be hearing from people representing doctors, people representing nurses, people representing paramedics, and they may be more helpful than I can be — and more helpful to the government in working on regulations in respect to what types of wounds would be accepted in the definition that a stab wound might receive in the regulations in that respect.

Mr. McGovern: — Mr. Chairman, I would just add to the minister's comment for the members that there are a number of American states, dozens of American states, that make reference to wounds in addition to gunshot wounds that we would be — as a drafting exercise with respect to the regulations — making reference to, to see if that helps in addition to the local consultations.

The Chair: — Thank you. That concludes the time allotted for our first witness. We thank you, Mr. Minister, and your officials, for being here. We will allow a few minutes for the transfer of witnesses before the committee and we will reconvene at exactly 2:30.

[The committee recessed for a period of time.]

The Chair: — Committee. We'll reconvene the committee if we could have some order, please. We'll reconvene the committee with the next witness which is the Information and Privacy Commissioner, Mr. Dickson. Mr. Dickson, would you introduce yourself and your officials.

Mr. Dickson: — I sure will. Good afternoon, Mr. Chairman. I'm Gary Dickson, the first full-time Information and Privacy Commissioner for the province. And with me is Clint Krismer, who just three days ago started as the fourth and newest portfolio officer in what we refer to as the OIPC, the Office of the Information and Privacy Commissioner. So a baptism of fire for Mr. Krismer — we told him we'd put him to work immediately.

The Chair: — Mr. Dickson, I will just remind you that you have a maximum of 20 minutes for your presentation and then after that we will go to a 30-minute question and answer period. You may make your presentation now, please.

Mr. Dickson: — Thanks very much. Good afternoon, Mr. Chairman, and members of the committee, and thank you for the invitation to participate in this public hearing. I applaud the committee's initiative to hold these public hearings on Bill 20. The issues raised are important and they are far-reaching. They deserve this kind of deliberation, this opportunity for public input, that your committee is providing.

As an independent officer of the Assembly, I have a mandate to provide comment on the implications for personal health information of proposed legislative schemes. This mandate's set out in section 52 of The Health Information Protection Act, I'll refer to as HIPA, and section 33 of The Freedom of Information and Protection of Privacy Act, at the same time I'll just refer to as FOIP [freedom of information and protection of privacy].

I've distributed to members a binder with some materials that I intend to refer to in the next 15 minutes. Tab 1 may look familiar. That's a submission of November 20, 2006 to the Legislative Assembly when the Bill was in an earlier stage of consideration. In addition to my written commentary, I plan to suggest this afternoon some seven amendments to Bill 20 for the consideration of this committee.

I suggest that this committee has a difficult task in dealing with Bill 20. I recognize that we have as a province a serious problem with criminal violence, with criminal gangs, and an increasing problem with the use of knives in the commission of crimes. And I'm certainly not here, Mr. Chairman, as some kind of privacy zealot to argue that privacy should trump all other considerations.

Public safety is important. Privacy is not an absolute right. What I think we're all looking for is a reasonable means of addressing both privacy and public safety. My advice to this committee is that Bill 20 fails to achieve that goal, that kind of balance.

Let me start by acknowledging, Mr. Chairman, there are a lot of unknowns with Bill 20. I might start by saying, where is the evidence to suggest that, even without legislation, gunshot and knife wounds resulting from criminal acts are not currently being reported to police? If you look at tab 10 in the binder, page 3, halfway down, I note that there's evidence that suggests:

> Suicide, an impulsive act, accounts for the majority of gun-related mortality, much of it among young men.

And:

> Of the homicides involving guns, the majority do not involve any other crime, are the result of disputes between people who are known to each other, and are impulsive acts that take place during, or following, a dispute.

Will Bill 20, Mr. Chairman, discourage injured people from seeking appropriate medical attention? Will it negatively affect relationships between providers and patients? I simply don't know, and frankly I'm not sure that anyone knows for sure. New legislation in Ontario and Alberta is simply too new to be able to evaluate all of the long-term impacts and consequences, and as you've heard, no other jurisdiction in Canada has gone so far as to contemplate stab wounds. I'll come back in a moment, come back to the Ontario and Alberta experience.

I would want to stress early on in my presentation that it's important we recognize — and there was some reference to this in the presentation by the minister — clearly where there is an imminent risk to somebody's health or personal safety right now, without Bill 20, there is a provision in section 27(4)(a) in HIPA, and that's set out at tab 3 in my material. So you can see the specific wording. I think the minister quoted; I just quote again:

> A trustee may disclose personal health information . . . without the consent of the subject individual . . .
>
> > where the trustee believes, on reasonable grounds, that the disclosure will avoid or minimize a danger to the health or safety of any person;

So that's in the law as it stands right now and as it's stood for the three-plus years we've had The Health Information Protection Act in force.

So that provision certainly deals with the case of the fellow who comes in with a stab wound to the local hospital and is aggressive towards hospital staff. It certainly deals with the case where hospital staff have some basis to believe that the perpetrator is going to come back to the hospital to finish the job by further injuring the patient in the hospital. In those cases there would be no reason why people in that emergency ward in that hospital couldn't pick up the phone, phone the police immediately — not just provide the name of the individual, provide any other information necessary and appropriate in the circumstances to ensure that the people in the hospital are safe. The purpose of that provision, I think, was to ensure that our health staff, people working in health care facilities, would not be put at risk because of some concern with privacy.

I can tell you though from the number of questions and calls my office receives and has received over the last three years from trustees around the province about 27(4)(a), there clearly is a need for more clarification about that provision. There is some confusion at the health trustee level and our office is working on this. Saskatchewan Health is working on it. But I submit there's no need for new legislation for this purpose.

The important power in 27(4)(a) is reinforced by section 24(i) where trustees must comply with a court order or demand, such as a subpoena or a warrant issued by a court without consent of the individual. They'd simply have to do it.

Really it seems to me that what's here in Bill 20 is something that goes far beyond issues of immediate threats to the safety of anyone in a hospital or in a health care facility. It appears what this is really about is facilitating police investigations which . . . Not saying that's not an important matter. But I think it's important to be clear, that's really what I think Bill 20 is about. It's not about keeping somebody safe in that acute care setting where they're receiving appropriate assistance.

As members of the committee will already be aware, there's no duty on citizens now — this is Canadian law — there's no duty on citizens now to volunteer information to the police about how they have sustained an injury.

Let's consider for a moment in practical terms what I think Bill 20 will do. Let's assume, Mr. Chairman, if I might, you're sharpening your hunting knife. You accidentally stab yourself and you go to the local hospital for treatment. So presumably there's going to be treatment. You're probably going to have sutures, perhaps a tetanus shot. But here's what further will happen, Mr. Chairman. The hospital will be required to call the local police detachment to advise that Ron Harper's being treated for a stab wound. They will provide the police in that telephone call not only your name, the facility in which you were treated, but also quote "any other prescribed information." We have no way of knowing how broad or how narrow that quote "prescribed information" will be.

Now I had the benefit of hearing the minister say, well that's not going to be the file. It's not going to be personal health information. I don't see that anywhere in Bill 20. Now that may well be the minister's intention, and I have no reason not to accept at face value that is his intention.

But the interesting thing about Bills, once they're written and once they become the law of our province, they're there. Different people come along. Different ministers come along, different people within the department. And there's certainly nothing, I think we can all agree, in the Bill that says this will never involve personal health information; it won't involve other highly personal and prejudicial information. Maybe at some point it'll capture information about your mental health because that may be highly relevant to people having to deal with an individual.

In this respect, let us assume then, Mr. Chair, that the police get the information. Perhaps you would have been willing to volunteer this information to police anyway. If you were not inclined to do so, the next step will be for a police officer presumably to come to your residence or place of work to interview you. You will still be under Canadian law, no legal obligation to provide any information to the officer. If you wouldn't divulge this information before going to hospital or at the hospital, what is the likelihood you will volunteer information in the police interview after you leave hospital? So even if the police are alerted someone has an apparent stab wound under Bill 20, it seems to me they still have the problem of securing that person's co-operation after Bill 20 has done its part. In that case, the investigation, I submit, is really no further ahead.

That's why I anticipate that police will no doubt press to expand section 7(c) significantly to enable them to collect more information from the hospital, the health care facility. Maybe they will want to collect mental health history of the patient and maybe section 7(c), if and when we see the regulations, may accommodate that.

What then happens to that information, Mr. Chairman? The police will presumably document this information from the phone call. Where will this go? How will it be filed? Where will it be stored?

It is likely it will be somewhere in the police record that Ron Harper sustained a stabbing wound on a particular date and received treatment. Can we be certain it will also show this was a simple accident and not a criminal act? Maybe the investigator isn't persuaded and thinks that Mr. Harper isn't being truthful and has noted his suspicion in the police file.

Maybe the only notation in the police record is a brief one and doesn't indicate the injury was an innocent accident but is coded in exactly the same way as a stabbing from a criminal assault. Maybe other officers who have reason to read this information at some future time mistakenly conclude that Mr. Harper was involved in a criminal act or at least was injured by a criminal act.

How long will this prejudicial information be kept? Who will have access to this prejudicial information? Will it be shared with other police departments, with correctional officers, with probation officials, and under what circumstances? Will this prejudicial information be able to migrate to the new national police information systems that are being developed, a number of them currently in development and being rolled out?

What we do know is that you, Mr. Chairman, cannot complain to our oversight office or ask us to investigate whether your personal health information is being improperly used or disclosed. You cannot make an access request to see the information about you or to have errors corrected and then appeal to an independent commissioner office if you're denied access or correction. This is because in Saskatchewan municipal police forces, municipal police commissions are not subject to our FOIP or local authority FOIP Acts.

So to prevent this from happening, what safeguards would be required? In a moment I'm going to offer some specific recommendations for this. But I refer members, if you look at tab 11 of the . . . This is an article we found in the *Canadian Medical Association Journal* written by Merril Pauls and Jocelyn Downie, and if you look at page 3 . . . I apologize. The copy we've given you has been kind of edited in my office already. I hope you can still make it out. But if you look at page three, and we've highlighted, I think, the quote:

> the real danger is not that a few people may be deterred from seeking care, but that many others, who see that physicians have become an extension of the police force, will choose not to reveal their drug use, will refuse to say how they received an injury or will not disclose their sexual practices for fear that this information will be used against them. This will make it harder for physicians to treat some of our most vulnerable patients and represents a significant breach of trust between physician and patient.

So what you have there, those authors are suggesting a kind of chill that goes beyond just a stab wound or a gunshot wound. It may be a percentage of the population that are involved in activities. And will they be deterred from seeking assistance? Will this be the Saskatchewan experience with Bill 20? I come back to tell you no one can say with certainty. I certainly can't.

But surely, Mr. Chairman, it's a risk with careful consideration before Bill 20 is enacted in its current form. In the paper at tab 2, you will see a paper from Wayne Renke who is a law professor at the University of Alberta, and there's an interesting discussion there about whether a mandatory gunshot wound reporting law is within the legislative competence of any provincial legislature. I've included a Supreme Court decision, Starr and Houlden, at tab 14 that talks about the limitations on a province's ability to legislate criminal procedure.

Now I don't think my place is to be here engaging in the debate with the constitutional law section in the Department of Justice. But I do think it's important that members be satisfied that in fact this is within the legislative competence of the province because certainly Professor Renke suggests that this treads in fact on federal criminal law. There's also the question whether Bill 20 could survive a Charter of Rights and Freedoms challenge. I flag these issues because I think they're important to deal with the Bill, going forward.

I've also noted in my submission Bill 20 is an example of function creep, Mr. Chairman. Personal health information collected for one purpose — namely diagnosis, treatment, and care of the individual — then disclosed for an entirely different purpose without consent or even without knowledge of the individual, function creep undermines public confidence in the integrity of health information systems. It undermines the respect that most sensitive personal health information warrants.

Now let me just move quickly to the amendments. I told you I had some amendments I would suggest to the committee.

Number one, consider — and I say all of this respectfully of course — defer passage of Bill 20 until the regulations have been developed, so we all know exactly what section 6 will mean and what will be exempted under section 7(e). The power in section 7(c) to permit regulations "prescribing any other information that must be disclosed to the local police service" is exceedingly broad. It challenges the right of the citizen to a reasonable expectation of privacy in respect of his person, of his medical condition, and services he is or expects to receive.

Those holes or gaps are not minor. They're substantial. And until we know how they will be filled, it's tough if not impossible to be able to say with any confidence what the impact of Bill 20 will be on the privacy of any of us. There are already plenty of questions about how Bill 20 will affect patients and providers. Why compound that uncertainty by deferring these kinds of decisions until some later date?

Number two, if the committee has already addressed the constitutional issues and resolved them to its satisfaction, I encourage the committee to at least eliminate the stab wound

provision. Restrict the Bill to gunshot wounds. In this respect I note the Ontario emergency medicine section of the Ontario Medical Association was a strong advocate in Ontario for mandatory gunshot wound reporting. Interestingly though, the same OMA [Ontario Medical Association] opposed reporting injuries from stabbings, and they provided reasons for doing so. And that's at tab 12 of the binder. It's page 2, paragraph 3 from the bottom, where they said, and I quote:

> We specifically argued against reporting injuries from stabbings and beatings in our paper and provided several reasons, mainly . . . this type of behaviour is less lethal; a stray punch or knife will never come through the wall of a house and kill a man watching television with his wife and child as a stray bullet did in Toronto recently.

We will be the only jurisdiction in all of Canada that requires health care facilities to disclose stabbing wounds. It extends the net, in my respectful submission, too wide, too far. It captures far too many minor, innocent injuries that should never be part of a police database. Mr. Chairman, the example of your stab wound, I simply don't think that information belongs in any police database that is effectively beyond the reach of independent oversight.

Number three, if you're not persuaded to restrict Bill 20 to gunshot wounds, you might consider the Alberta approach: making the disclosure a discretionary decision of the regional health authority and not a mandatory decision. With appropriate training, the care provider is better able to screen out the accidental stab wound, the accidental puncture wound. Why make this mandatory and remove the ability from our health care professionals to exercise appropriate judgment on the particular facts of any injury?

Number four, if you as a committee resolve to proceed with Bill 20 in spite of these concerns, I invite you to consider a requirement that the hospital advise persons entering hospital for what may be a gunshot or stab wound that there's a mandatory reporting to police requirement. This is consistent with section 9 of HIPA. That's at tab 4 in the binder. You'll see the provision there. I won't take time to read it, but it's about the transparency requirement that the Act is about letting people know what's going to happen to their personal health information when they come in for treatment.

Recommendation five, if you as a committee resolve to proceed with Bill 20 in spite of our concerns, I invite you to ensure that hospitals provide timely notice to patients that certain personal health information has been shared with police. This is after the fact. This would be in the spirit of section 10 of HIPA, which is at tab 5. The notice should detail the precise information provided to police. This innocent victim — in this case, you, Mr. Chairman, in my example — would at least know the police now have information about you and an injury you have received that they would not otherwise have had access to. This may already be captured by section 10, but it should be explicit in Bill 20.

Second to the last recommendation, number six, if you as a committee resolve to proceed with Bill 20, I encourage you to ensure that municipal police forces, municipal police commissions, are explicitly defined as local authorities in the local authority FOIP Act. Currently — and this is this weird situation we have in our province — currently the RCMP [Royal Canadian Mounted Police] when they perform municipal policing services are subject to the federal Access to Information Act, the federal Information Commissioner. They're also subject to the federal Privacy Act and the federal Privacy Commissioner. But there's no equivalent protection for those of us when our municipal police force — not the RCMP, our municipal police force — collects our personal health information as it would under Bill 20. I mean, it's different standards in our province and privacy protection depending on what community you live in.

With other public bodies, our office can deal with how long you keep personal information, how they keep it secure, how they ensure only those in the organization with a legitimate need to know can see the information.

The last amendment's a minor one. We focus, since HIPA came in, to ensuring we're focusing on regional health authorities responsible for health care in all the facilities in the region. I suggest you substitute regional health authority for hospital where that appears on the Bill.

So, Mr. Chairman, those were my comments. If there were time later, I'd be happy to, in three minutes, introduce the items and the other tabs I haven't mentioned. Thank you very much for your patience.

The Chair: — Thank you, Mr. Commissioner. Mr. Morgan.

Mr. Morgan: — Thank you, Mr. Dickson, for your presentation and for the work that you've done on this. You had indicated that you may have gone outside of your jurisdiction by commenting on the constitutional aspect of this thing. And I just want to tell you that we welcome that, whether or not it be technically within your purview. We think it's appropriate that you give as broad or as appropriate a presentation as you want. So you certainly haven't trod on my toes when making those comments in order . . . I think I'm speaking for everyone here.

My first question is, you had indicated in your presentation that if a person had chosen not to contact the police already or had indicated they weren't, as they were being transported to the hospital, or before they were transported to the hospital, that this Act wasn't serving a . . . [inaudible] . . . And I'm just wondering about the situation where a person was, as a result of their injuries, unable to speak, that they were unconscious or their injuries prevented them from speaking. Would, in that situation, it not be of some benefit to have the medical authorities contact the police so that the investigation could be started? They would at that point know the identity of the person and say, oh yes, that's the spouse that had phoned us three times in the last week. And then they would be able to look for the perpetrator.

Mr. Dickson: — Well the case you pose of the unconscious patient . . . I don't know. I'm thinking that in the course of being in the hospital and receiving treatment, the hope would be at some point this person would regain consciousness. I think that in my suggestion, where there's already provision, I mean if . . . When he regains consciousness, if then, from discussion with what's happened, you determine that there was a risk, they

could invoke section 27 (4)(a). If you're unconscious . . . I'm not sure what you do with that quite frankly, Mr. Morgan.

My understanding is it may be circumstances. I'm no medical person. It may be tough to tell whether an injury . . . If somebody comes in with a puncture wound, I think it's going to be darn difficult in some cases to tell whether it was an accident in the backyard or whether it was the result of a bar fight. Maybe health care people are going to be able to give you more information on that.

Mr. Morgan: — The logical extension of where I was going with it — you don't need to comment on it — was the situation where the person arrives unconscious, they choose not to contact the police and then the person ultimately dies. You know then we're dealing with a situation where, you know, we've postponed a police investigation. But anyway that's . . .

You had raised your concern — and I share the concern — about the regulations, and the regulations could significantly enlarge the purpose of this. Would your office have a higher comfort level if the reference to regulations was deleted and everything was embodied in a statute, or would you be comfortable seeing the regulations that are proposed? Regulations can always be changed of course.

Mr. Dickson: — Well I think my suggestion was that right now I think legislators are being asked to buy a bit of a pig in a poke. I mean really if you look at this Bill, it seems to me in some respects I guess you could say the guts of the Bill are not there. I mean they're going to be defined somewhere down the road. It's pretty significant deciding exactly what injuries will be covered and what won't. And it seems to me that this is entirely in the province of legislators, not the independent officer. But I think we would all have a much higher degree of comfort in seeing it spelled out now, either whether it's in the Bill or whether the government were to submit draft, a set of regulations saying this is the plan, this is sort of the other piece of the package, then at least we would all be a lot clearer than I feel we are today.

Mr. Morgan: — My last question is, would you have a higher level of comfort if the Act were to be changed to say that the injury was likely or the probable result of an unlawful act? Would that narrow the scope of the Act to the point that you would have a higher comfort level with it?

Mr. Dickson: — Oh sure. I mean I think part of my whole thesis is, you know, personal health information for most of us is sensitive and is prejudicial, and so the narrower that net is drawn, without compromising anybody's personal safety of course, the further off we are. I think I've suggested I'm really uncomfortable with police being able to acquire a whole lot of information on accidental injuries — I mean, what's that doing in a police database? — for the reasons I suggested before. So anything I think that narrows that and, you know, the minister's I think indicated, he sees a narrower view of that, but I'd suggest citizens might feel a lot more comfortable if that was nailed down before the Bill received Royal Assent.

The Chair: — Mr. Trew.

Mr. Trew: — Thank you very much, Mr. Chair. Mr. Dickson, I enjoyed your presentation. I have to do an aside and say I wasn't quite as enamoured with our esteemed Chair being stabbed repeatedly. I've never seen so much of Mr. Harper's blood on the floor in your hunting example, and I want to make it clear for the record that this was your example and you named our esteemed Chair in that — but lots of blood.

Your concerns seem to be, to me to be all around how much information the police get, and you have a high degree of uncertainty or . . . I think that's the word I'll stick with, uncertainty about future potential to change the information. As I understand the minister to have said — what the information is, is back to our esteemed Chair coming into the hospital with a stab wound, from hunting I'm quick to point out — that there's an obligation to contact the police. Say we have Ron Harper in whatever the hospital is — you know, Regina hospital or wherever it is — and he's had a stab wound. And then you made the comments around regulations.

My understanding of the way regulations are put together for Bills is, if there's a regulation change, there's a process of notifying the public that regulations have been changed. I submit that if a government, any government in the future, decided to significantly up the ante and start including information about infectious diseases or something like that or, in your example, mental health history, I think the public and legislators would have an opportunity — I'm thinking opposition primarily, you know, whoever the government of the day is and whoever the opposition is — they have an opportunity to raise that matter at that time. I think it's pretty clear from where I'm sitting right now that the intent is simply, so-and-so came into the hospital, they've been either shot or stabbed, and we have an obligation to report it. And then the police have an obligation obviously to follow up. I'd be interested in your comments around that.

Mr. Dickson: — Well I mean, it's certainly fair comment that presumably any future regulation is going to attract some notoriety and that people will be watching it. I'm simply focusing on the fact that . . . You know, I mean, we've heard comments what the department plans to do, but there's still those holes there in this Bill 20 that's in front of all of us right now and in front of you as legislators. I guess I can sort of only ask the questions, and it'll be for you as legislators and your colleagues to decide whether you're comfortable moving forward on that basis. I'm not sure I'm being responsive to your question.

Mr. Trew: — No, actually I think you are, Mr. Dickson. And I'm not going to take the time of the committee, but I do thank you for your presentation. I followed along. I thank you for the paper and the presentations. And you make some compelling and interesting cases.

Mr. Dickson: — I should say, you know, I guess one of the things about the role I have, you can say there's some sort of jumping at shadows and it's sometimes because when you deal with sort of the privacy world and just because there's a potential doesn't always mean that that's in fact going to be translated into government action. And so I guess in my role, I see part of my job simply saying there's some possibilities here. If legislators are comfortable that through other means they feel it's not the risk that I'm saying potentially it could be, then it's

of course for legislators to act accordingly.

Mr. Trew: — Again, thank you. Mr. Chair, thank you.

The Chair: — Mr. Yates.

Mr. Yates: — Thank you very much, Mr. Chair. I have a very similar question as I asked the minister a few minutes ago and then a slight nuance to it. Bill 20 as being proposed does not allow any greater disclosure of information than would be allowed today under section 27(4)(a), the way I read it. I look at the legislation. The only difference is one is mandatory. Today under 27(4)(a), the same information could be disclosed, is the way I would clearly read the legislation. And that's point one of the question.

And secondly you've raised under your recommendations issues about, you know, municipal police forces falling under FOIP. And are you aware of under the . . . This is a question that I'm not sure of, where under the Saskatchewan police Act, penalties and provisions to deal with the disclosure of information by a police force inappropriately, protections against that under that Act.

Mr. Dickson: — Just answering in reverse order the two questions. We've had a number of meetings with the Saskatchewan Police Commission, which in fact is a government institution for purposes of FOIP and the new, I think, title is police investigator. There's a new apparatus that's been created in our province to deal with complaints and so on. And I have to tell you, I mean they can deal with complaints and issues generally in respect of police, and there's a way of working those up through the process. But as I've indicated, they don't have any particular expertise or background in dealing with information kinds of issues.

And so if your question is, can a citizen who thinks something wrong has been done with their information complain to the local police commission, I think they can. And I think there's a process here to deal with it, but it isn't exactly parallel. It's quite different than the process we would follow with all other government institutions and complaints on those government institutions.

On the first question, actually I would beg to differ with the hon. minister and with your assertion. Section 27(4)(a) does not go nearly as far in my view as where Bill 20 would take us.

When you look at section 27(4)(a), there are three other jurisdictions in Canada that have a similar kind of health information law. And if you look at the way similar provisions are interpreted in other jurisdictions — and we're guided by that to some extent — the danger to the health or safety of a person, there has to be some conexus, there's got to be some . . . or nexus I should . . . there has to be some tie-in between the fear. It says "on reasonable grounds." And that means that it can't be kind of an abstract notion. I mean if somebody in the hospital is told, you know, somebody's coming to finish off the job, well that's a circumstance where 27(4)(a) would be entirely appropriate then to pick up the phone, phone the local police detachment and give them not just, as I say, name and that, but give additional information if that's what it takes to ensure that people are kept safe in that health care facility.

But what's being proposed in Bill 20 — as I say in my respectful view, and I do disagree with the minister — goes far further than what we would be, because for Bill 20 there doesn't have to be that connection.

Let's see if I can find it, and I hope I'm not going too far astray. If you look at tab 9, what we tried to do was look at some US jurisdictions that have similar kinds of reporting mechanism, and you will see there that in a number of cases, what's covered is a lot more specific. It's knife or gunshot wounds which appear to be intentionally afflicted, or gunshot wounds, knife wounds which result from various illegal or unlawful acts. That's much narrower than what we currently have in Bill 20 in front of us.

So I'm just saying that I don't see these two being, you know, kind of co-extensive or having the same scope at all. Section 27(4)(a) is narrower. And the way our office interprets it, and we've been working for three years with health information trustees helping to give them some advice in terms of what this means and we say, I mean, this is an exception to patient consent. So, you know, there has to be some reasonable basis to show that there is a risk of injury to someone or some people.

Mr. Yates: — Thank you very much.

The Chair: — Mr. Iwanchuk.

Mr. Iwanchuk: — Just following up a bit. I think, if I heard you correctly, you made this statement, that a lot of trustees from health facilities were calling your office about 27(4)(a).

Mr. Dickson: — That's right.

Mr. Iwanchuk: — But now you seem to be . . . I guess I thought I heard you defending that as being better or for offering some sort of clarity what we had. Maybe, you know, if you could explain that a bit more for me.

Mr. Dickson: — You know, I think what I didn't do a very good job is distinguishing between whether that provision is appropriate and whether all of us — Sask Health, our office — have done an appropriate job of communicating that to people working in health trustee organizations.

I have to tell you that when HIPA was brought into force September 1, 2003, frankly, as a province, we probably weren't ready for it. It was probably premature to have brought the statute in when we did. There was no material to go with it. In a number of other provinces — and they've done this — they actually produce a manual that explains what the statute means, what the requirements are for trustee. We didn't have any of that. And so what we've seen for the last three years is trustees wrestling to understand exactly what the fairly general wording in HIPA is.

And so I guess I'm trying to say . . . It's not that I'm saying that there's anything wrong with section 27(4)(a). It's just that we have to find ways of making sure that trustees who actually have to use it — make the decision — are clear on which is on what side of the line, you know, what's covered and what is not. And we've certainly been attempting to do that and in those communications that we have with them and through

conferences and meetings we have with regional health authorities and so on. Have I responded to your question?

Mr. Iwanchuk: — Yes, I think so. I guess what I was just confused is that when you started out saying it wasn't clear, and then you were defending it as being better or being more, you know, than the present legislation, than Bill 20 what was being proposed. I guess that kind of confused me because you first said everyone was calling your office because they were confused, which you sort of have said now, but in some of your other statements leading up to Bill 20 that you were saying that it was better or . . .

Mr. Dickson: — I think my view is that — if this helps — 27(4) is appropriate. It's an appropriate exception to the consent requirement. All privacy laws in Canada and internationally provide we don't want people standing around phoning a lawyer for privacy advice if there's an imminent threat to somebody's health or safety. Common sense dictates you take steps to keep the person safe because the consequences are so serious.

I . . . [inaudible] . . . would think it's as broad as Bill 20. Those would be trustees that haven't talked to us yet.

The Chair: — Mr. Dickson, just for clarification, do you have your seven recommendations tabbed here?

Mr. Dickson: — No, I'm sorry. I was revising them this morning. I'd be happy to provide the list to the Clerk of the committee forthwith.

The Chair: — Yes, if you would please do that as soon as possible. That would assist the process here. Mr. Huyghebaert.

Mr. Huyghebaert: — Thank you, Mr. Chair. And thank you, Mr. Dickson, for all the work you've done on this. It's been an awful lot of work and time put into that. I really understand where you're coming from and those have been some of my questions on this Bill also.

We've talked about it when the minister was here, or Mr. Morgan did, is he kept referring to acts of violence. And I guess how do you determine an act of violence if you're a health care worker? And that's a fine line that I'm having a bit of an issue with in my own mind. From a policing perspective, I could see where they may indicate to us that yes, we want all reported. And in your scenario about an accident — and I agree with that — like why would you have to get the police involved if there's an accident?

But from what I gather is your recommendations and what it is now, are we putting the onus back on to the health care providers to determine whether or not it's an act of violence and whether police should be called? And I guess we're going to hear from the heath care providers, but that might be one of their concerns is you're putting the buck back to the providers to say, I think this is an act of violence, therefore I will have to report it; or I think it's an accident, therefore I won't. Just your comments on that.

Mr. Dickson: — Sure. If you look at tab 6, that's an excerpt from the Alberta Health Information Act, which is roughly equivalent to our Act. Where it refers to custodian, that's the equivalent to a Saskatchewan trustee. You will see there it talks about:

> A custodian may disclose individually identifying health information . . . without the consent . . .

And then they go on to indicate:

> . . . where the custodian reasonably believes [now this is much broader]
>
> > that the information relates to the possible commission of an offence . . . and
> >
> > that the disclosure will protect the health and safety of Albertans.

So actually, it's much broader in that sense. But my understanding is that those people running health regions there and so on, they're working with this. This is fairly new, I think is only about a year old.

So once again, I'm not sure I could say nobody has any problems with it but when I talk to my counterpart in Alberta, this is seen as a workable, effective thing so far. So it seems to me there may be something we can take from that. And I do understand that you'll probably be hearing from provider groups who don't want that responsibility, but it seems to be working in the Alberta Health Information Act context.

Mr. Huyghebaert: — Thank you.

The Chair: — Mr. Trew.

Mr. Trew: — Okay. Thank you very much, Mr. Chair. Mr. Dickson, I was interested in your comments around a stab wound and your request that the committee not include stab wounds, you know, if we're determined to go ahead with the gunshot reporting as Ontario has done.

And I went back to tab 11 and, you know, read the top of I think it's page 3 that you had outlined for us. It's my belief as I reread it that in our earlier discussion, if in fact we're, legislators are convinced that what Bill 20 does is says, Ron Harper is in the Regina hospital suffering from a stab wound, and that's as far as the reporting goes to police. And they then drop by and see that it in fact was a either a criminal act while he was out hunting or an accidental stabbing as he was, you know, gutting the deer. Then that's sort of the end of the story. It either proceeds down the criminal lane or the other. And I don't think that would matter.

Tab 11 then, if that was as far as the reporting went from the hospital — you know, name, where he's at, and what the injury is — I think that would then take care of and allow us also to include stab wounds with the gunshot reporting, if in fact we're comfortable with the premise I've just outlined. Do you agree? Or what are your comments on it?

Mr. Dickson: — Well it's interesting when you look at the approach taken in other places. There are issues of lethality. I think that's the word that, in places that have looked at stabbing

wounds. And they've said, I mean, they . . . In one of the materials in the binder — and I'll be darned if I can remember the tab — there's a thing that said every time you use a firearm and somebody's hurt, there will be a violation of something. It may be an unregistered firearm; it may have been something that wasn't kept safely stored. So, you know, there's a kind of connection that . . . Some of those things don't apply to stabbing incidents.

You still have, even in the scenario you outlined, the concerns I have with this information then being in a police database, right? There's nothing in the Act that says once you've made that determination that the chairman . . . it was just an accident. There's nothing in here that says, okay it's then purged from the database. And maybe that's the police practice, whatever. But the point is that from a privacy . . . from my office's mandate and perspective we'd be saying, you know that's information that doesn't belong in that database, and it shouldn't continue to be there for some indefinite time period. And so that concern would still exist.

Mr. Trew: — Again, I'd just close with just one comment. I thank you for the work you do in outlining these concerns to us as legislators. I think it's a very valuable service that you provide, Mr. Dickson, and I thank you. I will again go through the binder you've provided us. Thank you.

Mr. Dickson: — I might just add, if I could, one of the interesting things. We had contacted our colleagues in other provinces — we often do in a case like this — what's their experience, what research have they done? And what I'm advised by the Ontario office, and I haven't had time to research this independently, but they've talked about difficulties in the US jurisdictions. And they've suggested to me — and I haven't verified this — but that the American Medical Association, the American Medical Women's Association, the American College of Emergency Physicians, the American College of Obstetricians and Gynecologists have taken positions against mandatory reporting of domestic violence. And there's a whole interesting body there, and I know the minister broached that. But I think that since a lot of the stab wounds happen in what we regard as domestic incidents, it's important to recognize that in other jurisdictions there isn't unanimous support by health care providers for mandatory reporting of those things.

The Chair: — Thank you, Mr. Dickson. That pretty well concludes our time here. We will be looking forward to — on behalf of the committee — to receiving your seven recommendations as soon as possible.

I also want to, on a personal note, say thank you very much for using me in your example. I muchly appreciate it. I'm hoping that that example will go a little ways to proving to my colleagues I do have blood running through my veins. I know that Mr. Allchurch disagrees with that because he has already stated that in order to have blood in your veins, you'd have to have a heart, and he doesn't think I qualify there. Thank you very much.

Mr. Dickson: — You're a good sport, Mr. Chairman.

The Chair: — Thank you.

Mr. Morgan: — Mr. Chair, I'd like to thank Mr. Dickson and his staff member for being here as well. We do appreciate the input and look forward to receiving the recommendations. It's going to be a difficult process to go through to find and strike a balance where we serve the needs of our police services as well as protecting the privacy of individuals. So it's input that's valued. So thank you.

The Chair: — Thank you. The committee will have a slight recess for the transferring of witnesses. And we'll reconvene at exactly 3:30.

[The committee recessed for a period of time.]

The Chair: — Thank you. We'll reconvene the committee. The next item of business for the committee is our witness from the College of Physicians and Surgeons, Dr. Kendel. Dr. Kendel, if you'll please introduce yourself.

Mr. Kendel: — I'm Dr. Dennis Kendel, the registrar of the College of Physicians and Surgeons, and I'm pleased to be here.

The Chair: — Thank you. We're pleased to have you. I'll remind you that your presentation is for a maximum of 20 minutes followed by a 30-minute period of question and answers. So we'll have your presentation now if you please, sir.

Mr. Kendel: — Thank you very much. I actually emailed a copy of the presentation. I think it was distributed to members of the committee earlier, and I will just touch on a few issues within that submission. I think I'll take considerably less than the allotted time and allow more time, if you wish, for interaction.

I didn't mention in the submission but I probably should for the record that, as the statutory regulatory body for medicine, we don't speak on behalf of physicians. It is the Saskatchewan Medical Association that speaks on behalf of physicians, so our perspective is a public interest perspective, taking into account the fact that the majority of members of our governing body are physicians, but there's also five public members of the governing body appointed by order in council, so it isn't just physicians that bring this perspective.

I pointed out that the College of Physicians and Surgeons was actually consulted during the course of development of this legislation. And because the consultation occurred between meetings of our governing council, the input was provided primarily by Mr. Bryan Salte, who is our in-house legal counsel, and myself as the CEO [chief executive officer] of the college.

A copy of the memorandum that Mr. Salte provided to the council was appended to my submission, and I think you can see from that document that basically Mr. Salte began from a premise that legislators obviously have a difficult role to balance the competing interests between privacy and public protection, and he respected the fact that ultimately you have to make these decisions. And he thought that although much of the detail of how this legislation would be applied would be fleshed out in the regulations, that on the face of it the legislation seemed quite reasonable.

When we actually though had an opportunity to discuss the matter with our governing council on November 24 and 25, the physician members around the table were not nearly as accommodating when it came to the issue of the stab wounds part of the Bill. They were quite supportive of that fact that gunshot wounds logically are more commonly associated with activity that's unlawful, and it might be eminently sensible to uniformly require their reporting.

Depending how stab wounds are defined, though, in the regulations . . . and I don't know if it is your intent to define stab wounds in the regulation. From a medical perspective, a stab wound is any injury that causes a break in the skin. So it could be something as innocuous as, you know, puncturing yourself stepping on a nail or something or reaching into the dishwasher if you like and if there's an upturned knife in the utensil basket, you could puncture yourself. So there could be very minor injuries.

And I heard a portion of Mr. Dickson's presentation, and I think that we probably have some commonality in the fact that if you overshoot the mark in terms of requiring reporting of a lot of things that are quite innocuous, you run the risk of losing public trust and understanding of what the thrust of the Bill is, even though it might seem harmless, I guess, for people to receive contact from a law enforcement agency to ask whether the reported incident was an accident or not and to have it followed up. If so many of those reports are really of an innocuous nature, I think you run the risk that citizens might feel that this is overly intrusive, and therefore you lose public support for what otherwise might be a very well-reasoned initiative.

So that brought us then at the council to discussing what might be a way to find a reasonable balance in this. And the council of the college didn't go so far as to say that it would urge you to totally abandon the reporting of stab wounds, but perhaps take into account that stab wounds to the trunk and the neck and the head of the body are more commonly associated with attacks on people. Injuries to the hands, anywhere on the upper extremity actually, are much more commonly associated with accidental injury.

Now we acknowledge right up front that for instance in the course of fending off an attacker, certainly people may incur knife wounds to the hands and upper extremities. So if you did exclude stab wounds to those areas of the body, there's no doubt that you will lose some reporting of some injuries that were probably associated with unlawful activity. On the other hand, you would probably diminish an awful lot of the reports that you would not want to actually capture.

I will then speak just briefly about the concept of putting the discretion in the hands of . . . I'll just talk about physicians because that's our statutory mandate, but the same principles might well be applied to other professionals such as nurses or paramedics. I guess some might argue that rather than having mandatory reporting of all such injuries, it should be at the discretion of a health care professional as to whether, in his or her opinion, the injury was likely associated with unlawful activity.

We're not entirely comfortable with that premise because, while it may be the case that in the taking of the history of an injury a health care professional does get a sense of whether this was likely accidental or not, people may give inaccurate histories because they want to avoid detection of unlawful activity, and so they may well describe a scenario in which a wound was reputedly incurred accidentally when it was not. So imagine for a moment if a health care professional senses that perhaps the account of the event isn't entirely consistent with the injury pattern. If in fact the onus is cast on the health care professional to make that triage decision, then I guess you compel physicians, nurses, others, to engage in a form of history taking which is more like a criminal investigation, as opposed to history taking for medical care purposes. And that probably would be a distortion of their function.

So if we're coming from a premise that the need to report such injuries is in the public interest and does override privacy concerns, I guess our view would be, better to make it mandatory with the very basic information that such an injury has occurred, has been treated at this site, and then leave it to police agencies to follow up as they think appropriate. It is axiomatic, and I believe this has been assumed from the outset, that this entire process should never interfere with the health care process. So that if in fact police agencies are able to respond, say, to the emergency department of a hospital while the person is still there, they ought to step back and allow all necessary health care to be delivered before any police investigations would begin. I think that's pretty axiomatic.

I would also understand that there's not any obligation cast on physicians or health care institutions to try and retain people at a facility if in fact the health care services they need are completed and, you know, that there would be expectation that they would somehow retain them so that police could arrive before they depart. Again that would be a mixing of roles that I think would be unfortunate.

So in conclusion I would say that I'll be pleased to answer any questions that you may have from having read Mr. Salte's memorandum to the council which includes a few other matters. He did in his position take a somewhat different view than Mr. Dickson has in terms of the balance between privacy and public good in this. And I guess we do acknowledge that there are other situations in which, by legislation, physicians are required to report things such as sexually transmitted diseases and evidence that people are unsafe to drive a vehicle and sorts of things . So the concept of having to report is not a foreign concept.

The legislation as drafted does place the onus on facilities to report. But I guess by experience we understand in some jurisdictions, particularly in smaller hospitals, the facility may in turn enact an internal policy putting the onus on either physicians or nurses. And I guess it would remain to see how that plays out. We would prefer that the facility themselves retain the responsibility through the administrative staff as opposed to making a particular front-line health care professional responsible for making a report.

And with that I will conclude my formal submission, and I will be pleased to answer any questions that members of the committee may have.

The Chair: — Thank you. Mr. Morgan.

Mr. Morgan: — Thank you, Dr. Kendel. When I looked at the paper and sort of had a chance to look at this, you've already answered one of the questions that I posed to the minister this morning. And the Act does not define stab wound, nor does it allow the regulations to sort of deal with that. So that's clearly sort of an area that we have to focus on because if, as you say, the medical definition of a stab wound — anything that breaks the skin — that would include virtually every motor vehicle accident and any other household trauma of virtually any kind where there's bleeding involved, would involve a break in the skin. So as we go forward, that's something that we want to do. Is there, in your view, a better word than stab wound other than . . .

I'll ask you my second question because you may want to answer at the same time. We had discussion as well as to whether the legislation should be broad enough to include injuries that were caused by blunt force or beating type injuries or injuries where there was no broken skin whatever or injuries caused by something other than a stab, something that was clearly criminal. So I'm wondering if there is other terminology that you may have or the college may have a higher comfort level with.

Mr. Kendel: — I think I would answer that, Mr. Morgan, by saying that any particular definition probably brings its own set of complications or perhaps unintended consequences with it. For instance when I said that a stab wound, generally interpreted, could include any breach in the skin I mean medically physicians often differentiate between a laceration and a stab wound. A laceration runs linear and you know is the sort of thing that you tend to get when there's a sharp object, whether it would be a knife or just a paper cut for that matter, you know, causes injury to the skin in a linear way. A stab wound by definition tends to be the sort of injury that occurs when an object which is sharp enough, or the force is great enough, to actually just penetrate the skin and go straight in.

Now when people seek to do harm to another person by using a knife or other sharp instrument, generally it's a thrusting action that you know puts the knife or other instrument into the body. And so I think if there's a word to be used, probably stab wound is the preferable word because otherwise if you use a much broader term you'll capture even a broader category of injuries. And again, I'm not sure that that would yield commensurate public protection benefits. So I can't offer a better term I'm afraid. I think the intent of the term is understood; it's just that maybe we need to limit in someway it's application.

Mr. Morgan: — What about other injuries that would be caused by blunt force or a beating or something like that, your opinion as to whether those should be. And I'll sort of tie that to my third question which is, if we were to change . . . You had expressed concern about not wanting to have to make a decision whether it was likely or probably. What about if the Bill said mandatory reporting unless it was apparently clear or abundantly clear that it was accidentally caused or the result of, you know, a motor vehicle accident or something that was outside of it; the reporting was mandatory unless there was, you know, sort of the onus was sort of shifted the other way?

Mr. Kendel: — Well that could be a very interesting concept because I think it does, even though the net effect might be the same, it does essentially enable the health professional to send a signal that in their opinion it's obvious this is not an accident. I guess, like everything in life, it has some interesting implications.

I think that carrying out functions like this in larger metropolitan centres where you go to an emergency department and you are attended by a physician whom you've never met before and may never meet again, it's relatively impersonal. When physicians practice in small rural communities, they know everybody personally. And I guess any time that you cast on a professional an obligation to either ensure that somebody is captured by a process or exempted by a process, you raise some potential for that to be subject to pressure and influence, I guess.

That can be unfortunate because, you know, if in fact by the nature of the legislation, people know that the only way that the police knew about this is that their good friend, the local doctor, thought they were involved in something unlawful. It may have more implications about the relationship going forward if they are going to continue to be in a doctor-patient relationship. Whereas if the doctor can say correctly because that's the way legislation is framed, it has nothing to do with that judgment, it is simply a matter of law that it must be reported, then it has no potential to cause that effect.

But I would agree with you, Mr. Morgan, putting it in the opposite, the sort of reverse onus would probably be preferable if that were going to be a condition.

Mr. Morgan: — I don't . . . No. Go ahead.

The Chair: — Mr. Trew.

Mr. Trew: — Thank you very much, Mr. Chair. Dr. Kendel, good to have you as a witness. It's always good to be in the same room as you if I might put it a little more generously.

We're told that the knife is a weapon of choice more often in Saskatchewan, relative to many other jurisdictions. I can't quantify it and say that we're number one or number two. But knife relative to gun, there's a higher prevalence of knife in Saskatchewan than in other jurisdictions. I hope I've made that not too muddled.

And the minister has said to this committee today — and it resonated with me — that the tools of an abuser are silence, and we need therefore, we need reporting. That's obviously the pitch he was making. And it cut some ice with me.

I was interested in your comments around mandatory versus discretionary reporting. And I think I would on balance favour mandatory so that my good friend, the local doctor, doesn't get in a situation of having the discretion of reporting whether I've committed an offence or may have or not. He simply has to or she simply has to, pardon me.

But my question . . . I think that where you can be more helpful to us is around, how can we word it so that we can eliminate some of the more innocent puncture wounds, stab wounds, if I can describe it that way, by the definition you used? I'm most

curious: is there some wording that would capture the huge majority of potentially illegal acts and, you know, leave aside others, while at the same time not leaving anyone the impression that our good friend the local doctor has some personal discretion around this? You know, I think we need very crystal clear regulations or legislation. How would you see that happening?

Mr. Kendel: — Well as the regulations are drafted — assuming they will be drafted — we would very much welcome an opportunity to sit down with the drafters and try and get people who are more on the front lines of providing this care to lend their expertise.

Although I carry the lofty title of doctor, I haven't practised medicine for 21 years. I've served as a regulator. And so the information I bring is partly, you know, gathered from other physicians who are in practice. But I didn't actually go to any great length at this point, Mr. Trew, to ask them whether they had any particular ideas about how we could limit, you know, the collection of inappropriate information but not miss important information.

I think the difficulty though . . . I still do know enough about medicine to tell you a few things. I mean, the difficulty with trying to define the injury — for instance, by the size of the entry wound or the depth of the wound — is fraught with all sorts of problems.

Because I mean, if you went to see a popular movie not too many years ago, the ice pick was the instrument of choice. Ice pick does not create a very big entry wound, but it certainly can lacerate the liver and the spleen and all sorts of other things underneath. Similarly so, you don't know the depth of penetration of a wound until you actually do some pretty invasive things. And so, just on the face of it, it's not possible for people to know whether this is a superficial or a deep wound.

I heard Mr. Dickson refer to the concept of lethality and again I guess in my simple view of this, I don't think the objective is just to do triage on the basis of whether the particular injury at hand was or was not life-threatening but rather, did it connect with some unlawful activity that puts people at risk in the future? Because surely the only thing we hope to achieve from this is to mitigate risk of violent attacks on people in the future.

So suppose a particular injury was not, didn't have great potential to be lethal but was the early sign of domestic violence or other forms of violence that need some intervention, then I do think that you want to capture those. So I don't have any easy answers.

I think when the drafting does occur, I'm sure that both we and the Saskatchewan Medical Association, which represents physicians, would welcome an opportunity to actually get some of our emergency room physicians engaged in discussing in very practical terms perhaps how it could be best framed. And we would offer to do that.

Mr. Trew: — Thank you. That sounds eminently sensible. I appreciate those comments, Dr. Kendel.

The Chair: — Mr. Yates.

Mr. Yates: — Thank you very much, Mr. Chair. Dr. Kendel, my questions are along the same lines. Obviously how this is drafted and how it moves forward is absolutely important. We do very much want to keep the doctor-patient relationship one that's supported in the community, but at the same time eliminate the possibility of those future perhaps significant injuries. And it's all going to be in, I think to some degree, how in the regulations we put forward the methodology to move forward on this. Because nobody also wants to have investigations of things that are clearly injuries, right. And there are a number of ways that those things can happen.

As we move forward on this particular piece of legislation, often the administrators in health districts or hospitals and that are also either doctors or nurses there so they perform actually a dual role, one of being the professional as well as the administrator. Do you see that as being a problem in that inevitably the people making the reports are likely going to be one of those levels of professionals in our emergency wards?

Mr. Kendel: — Well I can only speak from the perspective of physicians. And I think that when you use the term administrator, if we're talking about for instance the CEO of a health region, there aren't any physician CEOs because they can't afford to pay what physicians earn and there are precious few physicians in what I would say to be classical management roles that don't require medical expertise.

So there is in the new medical staff bylaws a position called the senior medical officer, and the person must by definition be a physician — is a member of the senior management team to manage medical affairs. So that would be the highest-ranking, you know, physician generally in a health region. In larger hospitals of course where there's clinical departments, there are medical department heads and they do have certain management responsibilities in terms of managing physicians.

But I get the, you know, the gist of your question. And we wouldn't see it problematic that if, for instance, the burden is cast upon the institution to report, but because of certain management roles, the person to report is a physician, then that's an inherent part of their responsibility. So we wouldn't see that as being some inherent conflict of interest with our code of ethics or anything.

I guess the one thing I just want to mention is that the principle at stake here is that physicians in their interaction with patients in any way — whether it's through front-line care or in a management role — are obligated to keep personal health information confidential unless that obligation is overridden by some other piece of legislation. And where that other legislation provides for disclosure, then they do so lawfully and we expect them to comply with the law.

As I did mention in my brief to you, if this legislation is put into force as it currently is framed or with some modification, we will accept the responsibility, along with the medical association, to educate physicians about their responsibilities under the Act and expect them to comply. Pretty fundamental concept of professionalism that we expect our members to comply with any legislation that's lawfully in place. So if that

comes about, then we'll have to educate them.

Mr. Yates: — Thank you very much.

The Chair: — All right then. Mr. Morgan, do you have . . .

Mr. Morgan: — I don't think I have anything else. I would like to thank Dr. Kendel and Bryan Salte for having prepared the information. I think the college is accepting that they're going to be the front line in applying this piece of legislation rather than the police officer; are the ones that have to make the judgment calls or the ones that are having to do it. And it's clear from Dr. Kendel's answers and from the material that they've directed their mind to it, and probably will have to go through the process of establishing the various protocols and everything that's in place.

The only other question, and if you don't want to comment on it, that's fine, is we had discussion earlier in the day about a situation where — as you'd mentioned, the onus is on the facility — whether it would be better to have the onus on health care providers. And what we were contemplating was a situation where a person was transported by, say, air ambulance or road ambulance for some distance. By the time they got to a facility as defined under the Act they would be so removed from where the offence would've taken place that the contact with the authorities would at that time be virtually meaningless. And I'm just sort of wondering whether you feel that it would be appropriate to have it somewhere else, put the onus on other people, or at least in a permissive manner that if it was satisfied by, say, an ambulance provider or an air ambulance pilot. And maybe it's something that you feel is outside of the purview of the college?

Mr. Kendel: — Well I think that's a valid observation. I notice the legislation allows for the definition of facility in the regulation, and that definition, I guess, could be framed quite broadly. But still a facility in most people's mind means a building as opposed to, you know, a service like air ambulance. The way health services are configured in this province — with the exception of centrally run services like air ambulance — virtually everything falls under one health region or another.

And I guess I'm not sure for instance whether the delay in reporting, you know, or the site from which the report comes is an impediment to . . . And this is outside my expertise. For instance if we're talking about which law enforcement agency has jurisdiction, I would think the report could still track back to wherever, you know, the incident occurred if that's the question of who has jurisdiction to investigate it. So I'm not sure how big a problem that is. But again if what we're trying to achieve is public protection and there needs to be some flexibility in terms of who reports, we're certainly open to that.

Can I just make one closing comment. This morning, you know, in the wake of the abandoned baby incident, some of our members called us and reported that they were being requested by law enforcement agencies to report if a young woman presented obviously postpartum and perhaps without evidence that she had a baby. And I guess this incident demonstrates very forcefully that our advice to them — even though this might seem very sensible to law enforcement agencies, it's unlawful. You cannot disclose personal health information except within the boundaries of the existing law, or there are some . . . We have some ethical considerations where, for instance, a physician in the course of health care learns of a person's intent to do harm to another person. So for instance in domestic violence situations, if a physician forms an impression that a person who is his or her patient intends to physically harm their spouse, they're authorized by us to breach the normal expectations of privacy and contact law enforcement agencies as a matter of protection. That's axiomatic.

But I think what's important about this piece of legislation is that in order to breach what is normally a pretty absolute expectation of privacy, society, through legislation, has to very explicitly define what are the circumstances in which it should be breached. And so if the definition of, you know, disclosing information gets too fuzzy then you get people equivocating and say, well I don't know whether I'll disclose this or not. And that's why the one thing we were attracted to in the construction of this legislation is its mandatory nature, that it leaves little doubt about the duty to report, and also makes clear to society that people who do the reporting are not on some sort of witch hunt, they're simply complying with the statutory provision.

And therefore I think that's a really important concept to keep in mind because if society gets a sense that either front-line health care professionals or their local hospital or whatever is playing loose and easy with their health information, then we will lose public trust. And so it has to be very clear that this is a situation where the public good overrides the normal privacy expectations and that it isn't a creeping thing, that it is well defined. So thank you very much for your attention and . . .

The Chair: — We have one other question, Doctor. Mr. Allchurch.

Mr. Allchurch: — It's just a minor question and that's in regards to your earlier comments about the stab wound legislation of this Bill, and that because of all the variables around stab wounds that it's a broad sense of what is right and what's wrong. Is there any problems regarding the College of Physicians and Surgeons in regards to the gunshot, mandatory gunshot reporting of this Bill?

Mr. Kendel: — No, at the administrative level we didn't see a problem. Even our council thought that on balance that's a much more easily justifiable, you know, reason for breaching privacy.

I must say though in response to Mr. Trew's comments earlier, I don't actually have hard data about what the relative incidence is of stab wounds in Saskatchewan compared to other jurisdictions. Certainly as a citizen just reading the papers and listening to newscasts, I do get a sense that stab wounds are a fairly common event. And so for that reason I understand why there was an intent to capture stab wounds because if in fact that's where the injuries are occurring, then we need to deal with it. On the other hand, most of the places where such legislation does exist is limited to gunshot wounds.

And we reviewed the literature in terms of, you know, how this applies in the UK [United Kingdom] and the US and in, you know, where it has been implemented in Canada and it's just

gunshot wounds there. But I agree that we may be different because of the nature of the history of injuries in this province.

Mr. Allchurch: — Dr. Kendel, as a spokesperson for the college of surgeons and physicians you must be in contact with all provinces regarding the same.

Mr. Kendel: — Yes.

Mr. Allchurch: — In regards to Ontario where they have legislation like this regarding gunshot but not stab wounds, are you familiar with Ontario as why they did not adopt that policy?

Mr. Kendel: — No, I wouldn't know because that would have been, you know, a decision by the legislators. We're in touch with our counterpart agency, the College of Physicians and Surgeons of Ontario and I don't know, for instance, what input they had to the legislation being drafted. But when it was drafted, they simply acknowledged it to be a piece of legislation that has implications for physicians and so they undertook to make sure that physicians understood their responsibilities.

So I don't know whether they took any position on whether it should go beyond gunshot wounds. I don't have that knowledge.

The Chair: — Mr. Trew.

Mr. Trew: — Thank you, Mr. Chair. Dr. Kendel, I have no more questions. I just wanted to thank you for the very thoughtful remarks you made on behalf of the College of Physicians and Surgeons and the governing body of it. And I want, just for the record, to know how eminently sensible it seems to me that the college should be involved in the drafting of regulations and I very much hope that that does happen, recognizing what we need is to make it work and work as efficiently and effectively as possible assuming that we proceed with this legislation.

This being day one of our hearings, I think we're recognizing that it's not all downhill. There's some very serious questions — you've raised some and others have and yet others will. But thank you for your participation.

The Chair: — Doctor, thank you very much for coming in. We appreciate your time that you've taken to be with us here and we appreciate the knowledge you've shared with us. Thank you very much.

Mr. Kendel: — Thank you very much.

The Chair: — Now, members of the committee, we'll now stand adjourned. The next group is slated for 4:30, although there's a possibility they could be here a little earlier. So I'm going to ask you not to be too far away in the event that we reconvene 15 minutes earlier; 4:15, say.

A Member: — At the call of the Chair.

The Chair: — Right on. Thank you.

[The committee recessed for a period of time.]

The Chair: — We'll reconvene the committee for this evening's sitting. This evening we have with us the police. I'm just trying to . . . who it is, the police organization. And so with that, if you, Chief, will introduce yourself and give us your presentation.

Mr. Weighill: — Thank you very much, Mr. Chair. Good evening, Mr. Chair. My name is Clive Weighill. I'm the chief of police for the Saskatoon Police Service, and I'm making a presentation on behalf of the Saskatchewan Association of Chiefs of Police.

The Saskatchewan Association of Chiefs of Police recommends the implementation of a gunshot and stab wounds mandatory reporting Act to assist police officers in Saskatchewan to prevent and interrupt violent crime in our province. In October 2005 the Saskatchewan Association of Chiefs of Police, or the SACP, passed a motion in support for the mandatory reporting of gunshot and stab wounds. The legislation requested is modelled after the Ontario legislation of 2005.

The proposed legislation will assist the police in addressing issues of unreported crime in the follow scenarios. Victims of unlawful acts of violence in some instances will not report the incident due to fear of retaliation. A serious injury resulting from gang activity may go unreported. This prevents the police from investigating and possibly conducting an intervention to further prevent violence before the retaliation escalates.

If an offence is not reported immediately, it severely hampers the evidentiary possibilities. Valuable evidence such as blood-soaked clothing, DNA [deoxyribonucleic acid] samples must be seized and protected to prevent contamination. If an incident is not reported immediately, police investigators lose the opportunity to protect crime scenes or photograph injuries.

In some cases, both the victim and the perpetrator are injured and both end up in the same hospital emergency. This allows the opportunity for a continuation of the violence within the hospital setting. If the police are not notified, it prevents their timely attendance to prevent such a continuation.

In many cases the most vulnerable in our society are victimized — those disadvantaged demographically, economically, and socially. If the incident is not reported, it prevents the police from intervening and possibly stopping a revictimization of the injured party.

In a case where an elderly person has been robbed and is unconscious, who would contact the police to begin investigation if the family cannot be contacted to report the crime? It may take hours to have the incident reported and valuable investigative time is lost.

Many violent crimes go unreported in this province. Remembering there is a victim attached to each of these crimes puts the reality of this into perspective. In fact, Regina alone has 165 to 185 victims annually report being shot or stabbed.

In Yorkton, a man was suffering from a near fatal stab wound and was quickly airlifted to Saskatoon. When members of the RCMP found out about the matter, they attended to the hospital where medical staff would not even acknowledge the event or

having treated anyone for such an injury. The offender involved in this incident was also being treated at the same time that the RCMP arrived.

The knife believed to be used in the stabbing was brought in the ambulance with the suspect and was in the lobby area of the hospital. Mandatory reporting of this incident would have allowed the police to initiate a proper investigation, rid the lobby of the weapon, and seize it as evidence. The lack of co-operation from the hospital staff had a huge impact on the speed and direction of this investigation and left emergency staff in jeopardy.

I must reiterate the importance of protecting victims from violent crime in our province. Most of these victims are our most vulnerable community members who are disadvantaged economically, educationally, and socially.

In 2004 the Canadian Centre for Justice Statistics, CCJS, reported an increase in the rates of violent victimization among our youth. We need legislation such as this to help protect our young people. The same CCJS report also reported that an Aboriginal person was three times more likely than a non-Aboriginal person to be the victim of violent crime. These are the people we need to keep safe.

Victims are often afraid to report the crime to police because of potential retaliation. Mandatory reporting takes that decision out of their hands and allows someone else to be their advocate, thereby minimizing the potential for retaliation.

Saskatchewan has been experiencing an increase in gang-related violent crime. In Saskatoon alone, there is a report of 303 persons associated with gang activity. Of these, 239 are adult and 64 are youth.

An interagency committee recently created a gang strategy for Saskatoon which includes three key strategic pillars to dismantle and disrupt gangs: prevention of gang formation; intervention by targeting and supporting individual gang associates; and suppression by crippling gang activity. All three of these can only be achieved with interagency communication and information sharing to identify those involved in gang-related activity and to begin the collective intervention process.

Such communication and interagency support must include our medical profession. The Saskatchewan Association of Chiefs of Police recognizes the concerns of the medical profession in regards to the privacy and confidentiality of their patients. We also recognize that as police we are not bound by the freedom of information Act. However the information that will be given from the medical practitioner to the police will not include any medical information but would simply give the name of the person victimized by the stab wound or gunshot, thereby keeping medical confidentiality intact.

The police are governed under The Police Act in Saskatchewan to ensure confidentiality of information and thereby follow similar rules and regulations imposed on the medical profession. We are held accountable by law should such confidentiality be breached. Rest assured we all have the same goal: the safety and the well-being of the citizens of our province.

Mandatory reporting of the name of the victim of a gunshot or stab wound would take the discretionary decision making from the hands of the medical practitioners and obligate them to report. This act in itself minimizes the potential for victimization by an offender or retaliation on the medical profession for making this decision to call the police, because they have no choice. The safety of our medical practitioners is important to the SACP.

Throughout the development and research of this legislation there's been a number of issues brought forward that I'd like to address. The number one issue: the goal of this legislation is prevention of further injury or death and enhanced community safety, but there is proof that mandatory reporting actually results in the reduction of gun-related/stabbing violence. The answer to that is the RCMP and the municipal police agencies in Saskatchewan report an increase in violence in gang-related activity. This activity tends to be retaliatory in nature and often creates victimization that is not reported to the police. To be proactive in preventing retaliatory violence, the SACP would like the legislation introduced.

Mandatory reporting of gunshots or stab wounds would assist the police in identifying possible secondary targets and would allow the police to be able to put resources in place to prevent retaliation from occurring. If the gunshot/stab wound was reported immediately, the police could be at the hospital in the event there is any confrontation between the suspect or acquaintances of the suspect. This assists in the safety of the medical staff and other patients.

This prevention is extended to any community member that may be in the wrong place at the wrong time when retaliation occurs.

The second issue is, why does Saskatchewan apply the Act to stab wounds when the Ontario legislation does not? Stab wounds are a serious cause for concern in Saskatchewan. Criminal activity in Saskatchewan fortunately does not currently involve the heavy use of guns. The weapon of choice are knives and blunt instruments. For the Act to be of maximum value in Saskatchewan, the focus is broadened to include stab wounds in an effort to ensure increased safety.

Issue number three. Would this mandatory reporting be a deterrent for victims coming to the hospital for medical attention? If they knew that it would be reported to the police, would they take the chance and not get medical attention to avoid a police investigation? In a research study performed in the United States involving 2,123 inmates, 91 per cent reported going to the hospital after they were shot, even when the wound was to an extremity and less likely to cause death.

Issue number four. In domestic violence situations the perpetrator may be the person getting medical attention for the victim. Would the mandatory reporting deter these perpetrators from accessing help for the victim? Some domestic violence situations would qualify under this legislation but most domestic violence is assault-based rather than stabbing or gunshots. Often after the incident the perpetrator feels remorse at what they have done and truly wants to help the victim,

which is the traditional motivation for bringing the victim to the hospital. Domestic violence, when kept private, often escalates. Just as with child abuse years ago, we should be addressing domestic violence in the same manner by reporting it to the police.

The fifth issue. Some opponents may say education and safety training are more effective tools than mandatory reporting in preventing gunshot wounds. The answer is, education is very important for the lawful handling and storage of firearms. Although education is extremely important, it has little effect in the unlawful use of weapons in the commission of such crimes as robbery, homicide, attempt murder, or gang retaliation.

In conclusion, the SACP supports mandatory reporting of gunshot and stab wound legislation. Although the legislation requires a violent incident is reported, it does not seek to have medical staff divulge any personal medical knowledge or history. It simply requires the incident is reported and the police can begin a timely investigation. The legislation will aid the police in protecting valuable evidence, thus increasing the probability of a successful investigation. It minimizes the potential for retaliation against those who report because they are obliged by legislation to do so. Most importantly, it helps the most vulnerable in our society from the possibility of continually being revictimized.

The Chair: — Thank you, Chief. Opposition members. Mr. Morgan.

Mr. Morgan: — Thank you for coming, Chief Weighill. You've raised a lot of issues that have come up from earlier presenters, and you appear to be going sort of in the same general direction as the department officials.

The issues that came up earlier are with the type of injury that's covered by this proposed legislation, the first issue is that it covers only gunshot and stab wounds. It does not cover wounds caused by blunt instruments, beating, or beating with something else. And I'm wondering, we'd like to hear your comments on whether the legislation could be considered to be broad enough that it would require reporting where somebody had been clearly the victim of a beating with a baseball bat, hammer, or even somebody's bare hands. So that was sort of one thing, if you would comment on whether you would like to see it extended.

And the other one is there is no definition in this Bill or a clear medical definition as to what a stab wound is. So the example that came forward this afternoon was somebody using a paring knife to separate frozen steaks and sticks it in their hand as one of the technicians had done, and my spouse. You know, under the legislation, that would have to be . . . you know, they required stitches. That would be a reportable incident. So we had a discussion with the doctors as to what discretion there might be on the medical community as to when they wouldn't report and when the statute would be relaxed.

So anyway we're sort of concerned about the definition of what's there sort of from both ends of the scale. So actually I'm asking two questions in one.

Mr. Weighill: — Well I think the chiefs of police would like to see the legislation much broader. But I think with the problems that we've had with The Health Information Protection Act in getting information to the police on serious medical injuries, we are, I think, just thinking if we could get this legislation it would be a good first start for us to move it. But certainly as I said earlier, the weapons of choice in Saskatchewan are not guns usually. It's baseball bats, knives, things along that nature. So whether somebody's been beat about the head with a baseball bat, and in our opinion should be reported as well too. But like I say, with what we've run into so far with The Health Information Protection Act, it seems to close the doors on us, so we thought this legislation at least would give us some place to start.

The Chair: — Mr. Huyghebaert.

Mr. Huyghebaert: — Thank you, Mr. Chair, and thanks, Chief. I think we all understand your position on this and agree with it. I think there's some fine detailing that we're looking at and back to what Don's comment was about the accidental stabbings. Now how much onus is that going to put on to your limited and pressured resources if you . . . And I don't know the percentage of ones that could be accidental. But every time somebody goes to an emergency room with a cut, they've got to report it by mandatory legislation, and there's no discretion involved. Now if you have to, in your limited resources have to go to do an investigation on each one of these, I don't know what your feelings are on that, but that's probably pressuring some very valuable resources when somebody along the chain knows that it was an accidental cutting of peeling potatoes or something.

Mr. Weighill: — Yes. Well I think that the legislation can be worded so that something to the effect of, wherein the medical practitioner believes a criminal offence has occurred or something along that line. I think common sense has to prevail on a lot of this stuff.

It's just like we're thinking of having a parks closing bylaw here in Saskatoon, and so people are up in arms because they want to walk their dog at night through the park. Well that isn't why we want a park closing bylaw. We want it so that we have some authority to move big gangs of youth out, so we have some authority to do that. We're not worried about somebody walking through the park with a dog at night. So I think with every legislation there has to be some discretion and some common sense.

Mr. Morgan: — Another comment that we've had was — and it's maybe outside of the purview of what you want to look at — and that's right now the onus is on the medical facility to make the report, which would be the hospital. The issue came up, what if somebody had to be transported from a significant distance to the hospital either by way of air or road ambulance or somebody else making the report if the person didn't go to the hospital, wasn't able to go to the hospital right away and broadening it to either imposing an obligation or protection to any EMT or medical ambulance driver or even possibly a police officer or a good Samaritan that may become involved. So I don't know if you have any comments in that regard or not.

Mr. Weighill: — Well once again we would be very supportive if an EMT practitioner was at the scene and could report that

there's been a gunshot or stab wound occur at that address. It certainly would facilitate our investigation getting along a lot quicker so we'd be very supportive of that, of broadening the horizon on that as well too.

The Chair: — Mr. Iwanchuk.

Mr. Iwanchuk: — Good evening. Just as the other members of the committee have mentioned, we've heard a number of people expressing different things. For myself what I'd like to know is basically the situation presently in, if I could, in Saskatoon that exists around this. What are you finding, and, I guess, you know, to get to this point, to request legislation?

Mr. Weighill: — Well we're finding a real frustration with health professionals. There seems to be a lot of confusion under The Health Information Protection Act. It does have areas in there that would allow reporting, but the health regions have consulted with the Privacy Commissioner. He has a view on how and what should be reported. I'm not even too sure what he's been saying to the health practitioners, but it would seem that they feel they can't talk to the police. Whether there's any situation, they cannot talk to the police so that leads us to frustration where we do know someone has been shot or stabbed.

We still get lots of calls from the hospital emergency whether they're supposed to report it or not because they think it should be reported. So we're attending to the scene. But when we get to the hospital, we're dealing with other staff who won't even tell us that there is somebody there or where the patient is. So I would say frustration is the main word right here. We just can't get any information at all. And you know trying to conduct any type of police investigation, sometimes we've had to threaten some staff to arrest them for obstruction. You know it's gotten really, it's gotten almost silly. There's no common sense.

It's a good legislation, The Health Information Protection Act, and I'm not here about that tonight. But that's what's driving this piece of legislation, is because we're so boxed in in what we can do, and there's such a literal view of a principle taken on that, that all common sense seems to have gone out the window.

And I guess my question would be to the committee here is if, as I mentioned it here, if your mother got stabbed and no one could get a hold of anybody and your mother got taken to the hospital, would you want somebody to call the policy and let us know? I mean that's where we've lost our common sense for this. It's just gone.

The Chair: — Mr. Yates.

Mr. Yates: — Thank you very much, Mr. Chair. We heard this afternoon concerns raised by the Information and Privacy Commissioner about the role of the police in keeping information private and that they don't fall under the same regulatory authority and regulations that government departments do, as an example, and some concern that the standards and responsibilities were not as strong for municipal police officers as they were even for the RCMP. Could you give us a little bit of what the real situation is or what the situation is involving municipal police officers and the level of accountability for confidentiality of information?

Mr. Weighill: — Sure, I'd be glad to, Mr. Yates. Well I can flatly refute his stand on that. We have the Saskatchewan police Act. As a chief of police and of a municipality, I'm responsible for discipline under the Saskatchewan police Act.

And I can tell you that there's been police officers fired from their jobs in both the city of Regina and both the city of Saskatoon within the past five years. I think three to four constables — I can't remember the exact amount between the two cities — have lost their jobs for breaching confidentiality, releasing information from CPIC [Canadian Police Information Centre] or releasing information on police files. So I think we've even taken it one step further. I mean civil employees can be fallen under the release of information. But certainly under the Saskatchewan police Act people lose their jobs for it or are disciplined very heavily, if they don't lose their jobs. So it's like old J. Edgar Hoover used to say, your secret's safe with us. If you can't trust the police to keep the files, I guess I'd have to say who can you trust?

Mr. Yates: — Okay. One additional question, there's also a concern raised about where that information would go and how it would be housed, and again some belief that if a report went in — as an example of somebody getting stabbed separating steaks — there may not be context. It may remain on a file and jeopardize somebody's ability down the road for any one of a number of things that you would check with the police about, the character of an individual. Could you enlighten us to some degree about how that would work within those files?

Mr. Weighill: — Absolutely. And I can speak for both Regina and Saskatoon. Our data banks are very similar, and there's different roles within our data banks. If you're a witness, you're roled as a W — as a witness on a file. So if anybody was ever to check your name, if we were to check Kevin Yates, you've reported many things in the past, your name would come up in our data bank. But it would just show that you'd been a witness to an offence. You role as a V if you're a victim, so that if you've been the victim of an offence, yes, your name would come up on our data banks, but it would show that you'd been a victim of an offence. So that would have nothing to do with a criminal record check. That would have nothing to do with your past record or anything like that whatsoever.

And what we're talking about a lot of the times here with this mandatory reporting is from a hospital, a lot of times it would be nameless. In the big cities we have hotlines that come in from the emergency. It's just a clerk at one end, at the emergency, coming in on the hotline to our police dispatch centre saying we have a stabbing at the hospital. We'd say thank you very much and send a car. So we don't even record the name in a lot of the times of the people that would phone that. So that wouldn't even be on the file. It would just come in reported from RUH [Royal University Hospital] hospital of a gunshot and we would attend.

Mr. Yates: — I think the concern being raised was, if in a situation of somebody was separating steaks at home, they cut themselves, that there might be some belief that it was spousal abuse or some other situation and some suspicion would remain on a file that could hurt the person without it being founded, without charges ever being laid. Could you enlighten us on what would happen in that situation?

Mr. Weighill: — Sure, sure. I'm sorry; I misunderstood the vein of the question there. Yes, there's definitely a possibility of that. You could be brought into the hospital, and we would investigate it if it looked like it was a criminal offence, and there would be a file on that. It would be roled at the end of it, though, if it was unfounded, that the file was unfounded. And that would never be brought up against anybody. That would not show any criminal record or anything of that nature. But it would still be in our police data bank; there's no doubt about that. Any file that we do have, it's always there. It's always kept on file.

So there could be a time where, like you say, severely cut with a knife, maybe if five or ten of those incidents came in, that one spouse kept getting continually cut with a knife, one might want to look into it a bit deeper. But by and large that would probably be the end of it.

If there's a one-time incident, certainly as the police, we wouldn't be saying, you know, so and so once reported to us that they had a knife wound and we thought it was domestic. If we don't have any evidence to go on, we wouldn't be making those little comments. So it would be a one-time incident. I can't see any danger of that. If it was repetitive, certainly one might be able to draw a conclusion that there's something going on. Thank you very much.

The Chair: — Mr. Allchurch.

Mr. Allchurch: — Welcome, Chief Weighill. One of the questions I have and that's regarding the Ontario legislation. And Ontario has not brought in the stab wound legislation. As a police chief and regarding the police, do you know offhand why in Ontario that may not have come in? Did it have something to do with the policing part of it?

Mr. Weighill: — I don't think that they're facing as many knife per capita, knife injuries as we would be in Saskatchewan, Manitoba, northern Alberta, or probably the Northwest Territories. Knives and, like I say, baseball bats are really the weapon of choice here. You would see more shootings occurring in the Eastern provinces than you would in the Western provinces.

So whether they thought it just wasn't enough of an issue to put in and how far they could push their legislation there regarding stab wounds and gunshots, but it certainly isn't as an issue per capita as it is in the Prairie provinces.

The Chair: — . . . took us out of synch. Mr. Morgan.

Mr. Morgan: — Would you be in a position to hazard a guess how many, what . . . you know, we'll catch the stabbings. We'll catch the gunshot wounds. But how many are we missing by not . . . I mean what percentage of attacks are we missing by not including blunt instruments and other acts of force? Are we missing half, more than half?

Mr. Weighill: — At least half because most of the stuff that does occur is a beating. They're kicked. They're punched. They're beaten, or they're hit with a bat or a pipe. Most of the street robberies you see on the streets, it's somebody gets pushed down, beaten up, you know, several kicks to the head, something along that nature. So we'd be missing at least half by not . . . at least, at least half.

Mr. Morgan: — Thank you very much. I don't know if anybody else has . . .

The Chair: — Okay. Andy, you'll have the last question.

Mr. Iwanchuk: — It's sort of two because I think I was missing out the, again, the amount of knives used in illegal activities. But you also had a . . . speaking about Saskatoon's gang or related sort of strategy.

Mr. Weighill: — Yes.

Mr. Iwanchuk: — I guess I wanted to hear something from you on how you see this assisting in that more directly than maybe was in here.

Mr. Weighill: — Okay. Well I think really where it assists is the victimization of people that are the victims of gangs. And what we see constantly is someone will get stabbed or shot, and they're very scared to report it. And if they do report it, the police have to spend a lot of time guarding those people to get them to court, and they have to guard the witnesses to go to court. And when they do go to court and try to testify, you have people sitting in the back of the court making motions like this to cut their throat or making motions like this to shoot them. And so they're very, very intimidated to report it.

This takes the onus off them of being the fink — put it that way — reporting it to the police, because they have no choice. If they get taken to the hospital and they're there, the result of a stabbing, it has to be reported to the police. So that takes the onus off them of telling on the gang people.

And really, probably you or I aren't going to get stabbed or shot. It's people that live in the inner city that continually get re-victimized and re-victimized and re-victimized because they're at such a disadvantage economically, socially, education-wise, demographically. And it's those people that we're here and we're trying to be an advocate for because if somebody doesn't step in and do an intervention and make sure those things get reported so those people are safe, a lot of times it will never be reported.

Mr. Iwanchuk: — It's just the other part, my other part of the question is, are there actual stats on knives, because we keep hearing continuously that there's an increase? And I mean, but . . .

Mr. Weighill: — You know, I haven't got . . . I couldn't give you the stats here in front of me today. I can tell you that the severity of street crime is increasing in both Saskatoon and Regina, that people are getting robbed for smaller amounts of things. And the severity, maybe not the actual number of offences — although street robberies are up in both cities — but the severity of the offence when it has occurred, has certainly gone up, the severity of the violence.

The Chair: — Could you provide us those stats at some point in time in the near future?

Mr. Weighill: — Yes.

The Chair: — The, you know, number of stab wounds, stab wound criminal activities and the increase in criminal activities even for smaller events and so on, if you could provide that to us, I think it would be quite helpful.

Mr. Weighill: — Yes. I'll make sure that you get . . .

The Chair: — Excellent. Thank you. Any further questions? Not seeing any. Thank you very much, Chief. Muchly appreciate your time.

Mr. Weighill: — Thank you.

The Chair: — Thank you for coming. Would you mind introducing yourself for the record?

Ms. Schriemer: — I'm Constable Joceline Schriemer with the Saskatoon Police Service.

The Chair: — Thank you very much. We'll have your presentation now.

Ms. Schriemer: — I'm going to come at this in a little bit of a different angle. My experience is 18 years as a police officer. And prior to that I worked in the health care system, primarily in emergency medicine.

Now I think when discussing this whole issue, we need to look at the importance of information that can be given to the police by the health care system. What we do know is that the life domains like education, health, justice, social services, all are interwoven. So an indicator, being an indicator of assault or a victimization will show up as an injury in the health care system, but it affects the justice domain in the person's life, as well as probably the social welfare of the person. For example, we know that people living in poverty have greater health problems as the SDH [Saskatoon District Health] study of our inner cities so well stated.

So something that we looked at — and Mr. Yates was also on the committee for sexual exploitation of youth — is that the indicator for the young person, the young girl working the street is in the education domain, not in the health domain. It is in the education domain. They start when they're about 14, and they start skipping school. So truancy is an indicator for something going on in that child's life. And sometimes it's working the street.

Now I talk about that because I want to bring in a duty to report with regards to injuries in the health care system for vulnerable people. Now the government has made the provincial child abuse protocol, and in that protocol there are several domains, several partners listed. And that's because indicators don't show up all the time just in one area. They overlap and that's why we need to share information, and that's why we need to look at things on a broader perspective.

When I talk about children . . . And we have special reporting for children in the provincial child abuse protocol. We also need it, I believe, for elders, mentally handicapped and physically handicapped. Now the commonality there with children is that the elders are usually dependent on their care to other people, and there is usually an emotional attachment to those people.

The verbal communication of the elder might be disabled, so there's not good communication for the person to complain that they're being victimized. And competency may be an issue because of dementia for seniors. And if we don't recognize those injuries or the neglect that these vulnerable people face . . . And primarily those things are going to show up in our health care system. So if we don't recognize that and if we don't report that to the powers that be in order to protect these people, I think we're making a mistake. And I think that we have a better society than that.

The senior abuse occurs in different locations. That's just for your information. Number five, types of senior abuse. But I do draw your attention to the fact that Canada has an increased senior population, and Saskatchewan is one of the leaders for increasing senior population. So if we need to be looking at this, and we need to be doing it sooner than later in preparation.

The other thing I would like to explain to the committee is what medical information are we looking at. What does medical information give us, the police? Now I draw your attention to a printout on the bottom of page 2, which is the various type of fractures. Fracture means a broken bone. Now you're all men so you're all probably good at physics, statistically speaking.

In order to have certain injuries occur to bones, there are certain things that need to be happening, and it's all a matter of physics. For example, an impacted fracture is something heavy falls on a bone and crushes it as opposed to a commuted fracture when a person jumps off a roof and has that kind of injury. Why is this important? It's important because signs and symptoms versus mechanism of injury.

When you are a health care professional and you're diagnosing something, the person tells you a story about how they were hurt, right. So for example, an old woman falls over on the street and breaks her leg, a bone in her leg. Mostly that break would be transverse or oblique, not spiral, because the spiral fracture comes from taking the leg and twisting it, torsion.

So when the doctor hears the story and the mechanism of injury does not fit the signs and symptoms, there should be questions. And when you have vulnerable people, they don't automatically tell you that they're victimized, especially elders, children, and mentally or physically handicapped people dependent on care. So that's what the medical information can tell us.

If I draw your attention to page 3 and 4, and this is significant for our . . . we call them seniors. The term elder gets confused with the Aboriginal culture, so I'll use the term seniors. That's a decubitus bedsore and that doesn't happen overnight. So when we are caring for someone who's bedridden and dependent on others' care, something like this, they just don't wake up with it Sunday morning and go to the ER [emergency room]. So when you have these kind of injuries that speak to neglect, those things need to be reported for proper investigation.

Now the police officers don't need to know the hemoglobin, how many sexually transmitted disease the patient had, if they're HIV [human immunodeficiency virus] positive. What

the police need to know is that this injury or this situation is suspect. The injury doesn't fit the story.

And I'll give you an example also of stab wounds. We were talking about stab wounds before. When a person is in a knife fight, one of the things that the victim usually shows is defensive wounds, so he'll have cuts on the hands protecting his body as the person's stabbing him. Now that's very, very indicative. That's something that, you know, you're going to have say a stabbing in the abdomen, but there's defensive wounds on the arms and the patient comes up with some cockamamie story that, you know, they ran into a knife in the wall or something, you know.

So those kind of things are present. Those indicators are present in our health care system. And it's not rocket science, but the mandatory reporting should pertain to of course stab and gunshot wounds because obviously there's a criminal offence that occurred. We need to be protecting our seniors and mentally, physically challenged.

Domestic violence, for example, you're going to end up with the same situations in the emergency room just as I spoke of. And what's very interesting is under The Victims of Domestic Violence Act, which was passed early '90s I believe, there's a section there called an emergency intervention order. What that means is it's a provincial legislation where in a home where there's a history of domestic violence, the victim feels that there's going to be violence again because of the cycle of violence and they're starting to argue but that person hasn't been victimized or assaulted yet, they can still call the police and the police can get an emergency intervention order and remove that person, the offender — or the suspected offender — from the home.

So this kind of doesn't make sense. We have legislation that we can take someone out of a home on the suspect that he might commit offence, and we have a woman who shows up, beaten with fists and bloodied and obviously been beaten — didn't fall down the stairs — in the emergency room, and we're not reporting it. And the offence has already been committed.

So suffice it to say that what's the intention of the legislation, HIPA, is the confidential medical information. And I think that is more than just a fractured leg. Those are those personal medical information things; you know, the person's on antidepressants that, you know, those type of things. Police don't need to know that.

So I understand that we need to keep that private. But we also need to be sharing information whose purpose it is to keep our society safe. Thank you.

The Chair: — Thank you very much. Mr. Huyghebaert.

Mr. Huyghebaert: — Okay. Thanks, Joceline. I think we really understand what you're saying here. What would your recommendations be to change Bill 20 as it is, as we see it right now, that could be more encompassing and broaden the scope with exactly what you're talking about?

Ms. Schriemer: — The recommendation would be to include in mandatory reporting, senior abuse; vulnerable persons, mentally, physically challenged; domestic violence; and any obvious injury that occurred from a criminal act, suspected criminal act.

The Chair: — Mr. Morgan.

Mr. Morgan: — I appreciate the extra benefit that this would give to minimizing elder abuse or minimizing domestic violence. I'm trying to think of it from the terms of a health care professional or a doctor or somebody in the health . . . Under what's proposed, all they would say is, we have somebody here that appears to be the victim of a gunshot wound or whatever.

But to make this meaningful I guess my question is, what other information would be there? You've said they wouldn't be required to give information about an STD [sexually transmitted disease] or something else. But I'm wondering what information, you know, because we'd want to either specify it either in the Act or in the regulations, as to what other information should be given.

And we haven't had a chance to talk amongst ourselves yet, but I see that the Alberta legislation refers to the nature or illness of the individual. So I don't know whether that's sufficient or whether you'd need more information. Like you've talked about the type of fracture, you know, the type of things would lead . . . made reference specific to a bedsore or something.

Ms. Schriemer: — Okay, I'll give you an example. A senior presents in the emergency room with a cracked rib and there's bruising around the area of the cracked rib. The story that the caregiver of the senior, to the emergency room doctor or nurse, is that mom fell off the step and hit her chest and cracked her rib.

Now if mom were to fall off of the step, what other injuries would she have? This elderly person would have scrapes, bruising on the arms as she tried to protect herself on the fall. There would not only be an isolated bruise with a cracked rib underneath. That suggests that mom was probably punched in the rib. So in medicine they investigate. In fact, a diagnosis is an investigation. And so this wouldn't make sense.

So the doctor could phone the police and say, I'm suspicious of this injury; she says she fell, but the mechanism of injury doesn't meet the symptoms. Police officers will . . . And they'll figure it out because they'll know in their head.

So then the object of the investigation at that point would be to talk to the elder and ask them what happened and make sure you do it alone, no different than with children. And so you want the elder to feel comfortable. A police officer can explain how we can protect you, how the system works, yada yada yada, and hopefully the elder will say, yes well my son punched me. Does that answer the question, Mr. Morgan?

Mr. Morgan: — I think so.

The Chair: — Mr. Yates.

Mr. Yates: — Thank you very much, Mr. Chair. Looking at some of the areas that you have proposed to move into, would mentally or physically — primarily mentally challenged

individuals or people with dementia — you would be able to detect perhaps that the story doesn't match the injury.

But you might have difficulty or not be able at all to get the story from the individual because they can't provide it, either for reasons that they can't remember perhaps or they don't have the skill, in the event of an intellectually challenged individual. So could you explain to me how you would see protecting that individual further in a scenario like . . .

Ms. Schriemer: — That's where our crossover in the life domains comes in. If there's a communication issue or competency issue and on the surface there is something that's suspect, I would call Social Services.

Mr. Yates: — Right.

Ms. Schriemer: — Which is now, I can't . . . DCRE [Department of Community Resources and Employment].

Mr. Yates: — DCRE. And I understand that, but I'm not sure that we'd ever get to what actually happened. And I'm not saying there aren't ways to protect the individual further but it might be very, very difficult in a scenario like that to actually discover exactly what happened because the people you'd have to go to for information may in fact be the perpetrators. Right?

Ms. Schriemer: — Absolutely. I think you have to trust that the investigation would go forward as best it can and that the object of the exercise would be the safety of the victim. And that may mean moving him from one home to another, and that's where the interagency work comes in with the goal being . . . I guess the question is, would you rather we not investigate at all? And then what would happen to that person?

Mr. Yates: — No. I'm just trying to understand all the implications, and as we move down — if we do move down that road — what other supports need to be put in place because it's not a simple, one-step mechanism.

Ms. Schriemer: — No. And I think that we just need to look at the provincial child abuse legislation. The model is there. The model is there.

The Chair: — Mr. Morgan.

Mr. Morgan: — I had posed a question to the chief, and I'll do the same to you. And it may not be a question that's appropriate to ask a police officer, but the Act as it's drafted talks about putting the onus on the facility. And I wouldn't mind hearing your thoughts about expanding it or changing it so that it would include an EMT or a paramedic or somebody else who would be in the chain of contact from when they first sought medical attention to when they were at a facility which appears — by the definition we have now — to be just a hospital. Because the example we talked about this afternoon was supposing somebody was brought in by either a, you know, lengthy road trip or by air ambulance, would it be appropriate to have those people tasked with notifying the police as well? And I guess your . . . if there are any reasons for or against that.

Ms. Schriemer: — I think that the onus of reporting — and I'll look to the child abuse legislation — the onus of reporting I don't think should be this facility. I think it should be the health care worker that comes into contact with the patient, be the doctor, the nurse. But as in the child legislation, somebody who suspects that, well knows for a fact that there's a gunshot wound or a stab wound or suspects that there was a violent act that caused this injury, that person should have the onus to report. So I guess, like in the child abuse legislation, everybody that has contact with that patient over a period of time, or everybody who's had contact with that child over a period of time has the onus to report. That way it will get done. Somebody will pick up the phone.

Mr. Morgan: — Thank you very much.

The Chair: — Thank you very much. We appreciate your time you've taken and the input you've given us. Thank you very much.

Ms. Schriemer: — May I give you examples of what has happened in Saskatoon?

The Chair: — Sure.

Ms. Schriemer: — Okay. There was a drug addict that was beaten with a hatchet and he had cuts on his head and arms and all this kind of stuff. That wasn't reported to police. It was a drug debt owed. And the perpetrator went without an investigation, punishment, whatever. We know this to be true through other means. That person, the victim presented in an emergency room in Saskatoon. And the process that they're using in Saskatoon is, the nurse went up to this person and said, would you like us to call the police? And this person said no. Now, you know, defensive wounds, everything indicative of an attack, and the person that we have information that did this shouldn't be on the street. It's a public safety issue. We're letting bad guys go, is what's happening.

In another case one of our people who's been in trouble a lot suffered a beating, twice, with bats causing broken bones and many, many stitches in the head. That also went unreported.

It's not up to the nurse or the health care professional to go to the victim and say, you were stabbed; would you like us to call the police? It's up to the police officer to go to the victim and say, what happened? I'm here to help you. If the victim doesn't want anything to do with us — and that does happen over sometimes — they usually say, you know, they'll tell you to go away and say, I'll handle it myself. And that's fine; at least we know about it.

I haven't been able to confirm this piece of information, but a person showed up in the emergency room with burns sustained while cooking methamphetamine. Now methamphetamine labs are highly, highly dangerous. They're a public safety issue. We have absolutely no information on where this is, if it is. And so those are the kind of things that we're closing off by having this legislation. Thank you.

The Chair: — Final question, Andy.

Mr. Iwanchuk: — Thank you, with indulgence from the Chair. We were . . . or at least hearing things of who would do the reporting. From what you have just said, that there was an

indication from health care professionals of wanting to report. Of course when they ask the person they say, no don't say anything. One of the issues that was raised was what made this Act, why people liked that, it was the mandatory to report. But it was very clear. You just simply reported it. So then we were struggling with what it would mean to have a knife wound. You've obviously opened up this, broadened the whole issue.

But because we're now hearing then two things, because I think there's at least . . . I was sensing that there was a reluctance where people were not afraid, but there was some question as to who would report this. So you had mandatory reporting which . . . Then anyone could just phone. But you are bringing in some, you know, different sort of things that it's almost, you know, it is like the abuse where it's the responsibility of all of us to report abuse. I'd just like to hear some of your comments. Are you finding that the health care professionals are wanting to report?

Ms. Schriemer: — Very much so. My husband and son and daughter all work as paramedics in this province and we have social friends that are health care professionals. And the many health care professionals that I've spoken to think this is absolutely ludicrous, that it's just wrong. And what I've heard is that one of the examples they used when being briefed on HIPA by SDH lawyer was, you know, we go to a call as a paramedic and a guy falls down the stairs and has a broken leg, as he was walking down the stairs to go and package up his cocaine. They were told they can't report.

So I guess, you know, that's a little further on the edge, but the point is how do we balance this, you know. As the chief said, the common sense has just gone away, you know.

Mr. Iwanchuk: — Thank you.

Ms. Schriemer: — And I'll add that it's not hard to document reporting. When you transfer a patient from a medical facility to ambulance to another medical facility, the charts go with them, and those charts are the documentation of the patient. So if the police were contacted and it was a stabbing, they could chart it, Prince Albert police contacted, notified, whatever. So it wouldn't be hard to do that in the system.

The Chair: — Thank you very much. We have one more set of witnesses, just check and see if they're here.

Good evening. The final presenters for this evening is the Saskatchewan Medical Association. Doctor, if you would introduce yourself and your official with you.

Ms. Doig: — I am Dr. Anne Doig. I'm a member of the Board of Directors of the Saskatchewan Medical Association and with me tonight is Mr. Marcus Davies. Marcus is the association's director of communications and government relations.

The Chair: — Thank you. I'll remind you your presentation is to the maximum of 20 minutes. And if you'll give us your presentation now, please.

Ms. Doig: — If I can talk fast enough? Good evening, Mr. Chair, and members of the committee. And thank you for allowing the SMA [Saskatchewan Medical Association] to make our presentation to you tonight on this piece of legislation.

We'd like to begin by just briefly introducing you to the Saskatchewan Medical Association. The SMA is the voice of organized medicine in Saskatchewan. It represents specialists, general practitioners, postgraduate medical trainees, and medical students. Our 2,000 members provide primary and specialized care in every region of this province.

The mission statement of the SMA is to advance the educational, professional, and economic welfare of Saskatchewan physicians, to advance the honour and integrity of the profession, and to promote quality health practices, quality health services, and advocate for a quality health system for Saskatchewan.

The physicians of Saskatchewan are significantly worried that the proposed Bill 20 will encroach dangerously on the ethical approach to patient-centred care. The four principles of medical ethics are beneficence, non-maleficence, autonomy, and justice. The proposed legislation, in the opinion of Saskatchewan's physicians, strikes at the principles of autonomy and justice.

Autonomy means simply respect for the individual. An individual has the fundamental right to exercise control over his or her person. For tonight's discussion, I will focus on two elements within the principle of autonomy that will be offended by the proposed legislation — the elements of privacy and consent.

The principle of justice means that all people have the right of access to an equal standard of care. Justice is often represented by a blindfolded figure. In medicine, this means that we are blind to being influenced by the circumstances of a person's illness or injury when we provide care.

The physician-patient relationship is called a fiduciary relationship because it is founded on trust and reciprocal honesty. Trust demands a great deal of responsibility, not the least of which is the responsibility to protect the patient's privacy and the confidentiality of the patient's personal health information. It is fundamental to the provision of medical care that the dialogue between a physician and a patient must be honest and complete.

There is a risk that patients will be less than honest or will withhold information unless they believe that information about them will be kept confidential. There is a risk that patients will avoid necessary care if they fear disclosures about themselves or about the circumstances of their illness or injury.

Our code of ethics is clear about fiduciary duty of physicians to protect the privacy of the individual and the confidentiality of personal health information. In addition to our ethical code, governments have made the duty to protect privacy explicit and have extended that duty beyond individual health practitioners who are governed by their professional codes of ethics.

In Saskatchewan The Health Information Protection Act defines statutory requirements for the privacy of the individual within which physicians, other providers, and other trustees such as regional health authorities carry out their duties to patients.

There is a fundamental premise acknowledged by government in The Health Information Protection Act that personal health information is different from other information. Personal health information is collected by the physician or other health care provider for the primary purpose of promoting the health and well-being of the individual about whom the information is collected. It is to be used only for that primary purpose. Personal health information may be shared with other providers for the primary purpose. Any other use or disclosure of personal health information may occur only with the consent of the individual, except in certain explicitly defined circumstances.

The reasons for this may be obvious, but they deserve to be stated. Personal health information is, by its nature, intensely private. Personal health information has the potential for significant impact on the life and future plans of an individual if it is used inappropriately. Our patients understand that. They undertake their relationships with their physicians on the basis of that confidentiality. The assurance of confidentiality is what allows them to speak frankly and in turn allows us to provide the best medical advice.

The assurance of confidentiality, without which the provision of the highest standard of medical care would not be possible, extends to all patients in all circumstances. We owe the same ethical obligations to every one of our patients regardless of the situations and circumstances that surround their needs for our services. It would be truly disturbing to us if it were any other way.

Physicians believe that this Bill, if passed, will require physicians and other providers to breach our fiduciary and statutory duty to patients to preserve the confidentiality of their personal health information. We worry that this breach of trust will undermine the relationship that exists between our patients and members of our profession and will compromise their care.

The importance of consent in health care delivery is recognized in The Health Information Protection Act and in the ethics of our profession. Consent is another of the elements of the ethical principle of autonomy based on the belief that each individual has the right to make choices regarding his or her care and regarding the use and disclosure of personal health information.

There are very rare circumstances in which a physician will act without consent, usually only in the best interests of a patient who is unable to provide that consent in an emergency situation. Emergent situations typically involve treatment decisions and rarely if ever require a physician to disclose personal health information to anyone other than another health care provider who is involved in the care of the individual. It is virtually impossible to think of a situation that would justify emergent non-consensual disclosure of information to third parties such as the police.

Physicians are accustomed to providing certain components of care under the assumption of implied consent. When a person presents him or herself for care, the fact of having done so is an indication of consent to care. Their reliance on implied consent demands of physicians that they exercise the utmost discretion in determining the limits of that consent. Except in emergencies, physicians do not assume that patients have given implied consent for invasive or risky procedures. Similarly, we do not assume that patients have given consent for information about them to be disclosed.

In the circumstances considered in this legislation, the patient or a legal proxy for the patient will at some point be able to provide informed consent to release information to the legal authorities. There are no grounds for a physician to assume that a patient would consent to the disclosure of information to the police.

There are exceptions governing when a physician may release a patient's personal health information without consent. And we believe these exceptions already address the desired effect of the proposed legislation. It is already recognized in our profession's code of ethics, in common law, and in practice that a physician may disclose a patient's personal health information when not doing so would pose a significant risk of harm to the patient or others.

Members of our association regularly act in accordance with this important exception — in recent memory in a instance where a physician had convincing reasons to believe he had treated the perpetrator of a number of serious violent offences and that others would be in danger if he did not act. We are not convinced that there is a need for an imposed statutory obligation, especially one which may come at such a high cost to our care of our patients.

So far I have spoken only of the relationship between the physician or other health care provider and the individual patient. Physicians also have a duty to society but that duty is always secondary to the duty of care for the individual. However, physicians have recognized and governments have enacted legislation to govern situations where physicians must disclose information about individuals to serve a greater public good. Nominal disclosure of diagnoses of notifiable diseases to the medical officer of health is one example.

Similarly, physicians and governments have recognized situations where personal information must be disclosed to prevent harm to an individual, particularly when the individual is unable to exercise autonomous action to prevent harm. The duty to report the suspicion of abuse or neglect of a child is an example of this type of statutory disclosure.

However, governments have not seen a need to extend the duty to report risk of harm to such situations as spousal abuse. Physicians and other health care providers have no statutory duty to report such situations. Similarly, in situations such as a motor vehicle accident, the police have no right of access to information about the victims of the accident. And physicians have no duty to report except as required under the provisions of The Saskatchewan Government Insurance Act.

Sexual assault is a circumstance that could be seen as a parallel to a physical assault such as a shooting or a stabbing. Government has not seen the necessity in pursuing the perpetrators of sexual assaults to mandate the disclosure of information about such assaults to police. On the contrary, a person who seeks treatment for the effects of a sexual assault must provide explicit, informed, written consent both for the collection of the forensic evidence of the assault and for the disclosure of information and the evidence kit to the police.

And these are two separate consented items. If the patient refuses consent for disclosure, the physician remains under an ethical obligation to treat the patient and must not disclose information about the assault.

Physicians are not derelict in their duty to advise patients to seek appropriate protection from harm. If we know that a person has been injured as a result of a deliberate act by another person, we will advise the person to contact police. Under those circumstances physicians will, with the consent of the patient, disclose information to the police. It is the patient's decision to report, not a decision imposed upon the patient by the physician.

The question to be asked in respect of the proposed Bill 20 is whether the requirement to report stab and gunshot wounds is for the purposes of protection of a person or group of persons or is for the purpose of law enforcement. I have already discussed the limits on disclosure for protection from harm. If the purpose of the requirement to report is for law enforcement, an even higher standard must be satisfied that the goal has sufficient public merit to override the rights of the individual and the fiduciary duty of physicians.

I will discuss later the impact this could have on individual patients, but I think it is worth noting the public policy reasons why the health care system has never before been used as a branch of law enforcement. The relationship between individuals and law enforcement are profoundly different from the relationship those individuals have with their health care providers. The primary duty of law enforcement is to society. The primary duty of a physician is to an individual. Law enforcement becomes interested in an individual because of suspicion, a criminal record, disreputable associates, or a myriad of other reasons, all of which are based in distrust. The relationship between a health care provider and an individual patient must be exactly the opposite. It must be based on trust and any element of distrust could in fact destroy the relationship.

Blurring the lines between relationships built on two very different, even opposite foundations is anathema to physicians. We are not and cannot be seen to be a branch of law enforcement. This is not to imply an adversarial relationship between physicians or other health care providers and the police. It is simply to state that their responsibilities are different.

Mr. Yates: — Sorry. We just have the first three pages of the report. That's why we're looking a little . . .

Ms. Doig: — I began to wonder if there was a mouse running around under the tables or something. That's all right.

I'll just repeat the paragraph that we were on before we did that. Blurring the lines between relationships built on two very different, even opposite, foundations is anathema to physicians. We are not and cannot be seen to be a branch of law enforcement. This is not to imply an adversarial relationship between physicians or other health care providers and the police. It is simply to state that their responsibilities are different.

I believe it is worth repeating a quotation from an article that appeared in the *Canadian Medical Association Journal* in 2004:

> If physicians are obliged to report gunshot wounds, the real danger is not that a few people may be deterred from seeking care, but that many others, who see that physicians have become an extension of the police force, will choose not to reveal their drug use, will refuse to say how they received an injury or will not disclose their sexual practices for fear that this information will be used against them. This will make it harder for physicians to treat some of our most vulnerable patients and represents a significant breach of trust between physician and patient.

Our most vulnerable patients — these are the individuals whom we fear could be affected most detrimentally if our concerns about elements of this legislation are not answered. These are people who do not need another obstacle standing between them and an honest relationship with their physicians.

We have heard that government needs this legislation in order to tackle gang violence in our inner cities, and we applaud the government's interest in this issue. Please remember however that it is our members who actually see both the victims and the perpetrators of this violence. We treat them and provide the best care by establishing, often very quickly, a relationship of trust in which these individuals can share such important treatment information as drug and alcohol use, sexual practices, and so on.

As I said previously, the ethical principle of justice demands the same duty of care to every one of our patients regardless of the situations and circumstances that surround their needs for our services.

As has often been pointed out, for many families in inner city communities, the emergency department is the first and often only point of contact with the health care system. Once that place of trust becomes viewed as an outpost of law enforcement, we have good reason to be concerned that access to health care for these vulnerable people will diminish even further. It will only take one breach of trust, one incident in which an unwilling victim of violence is turned over to police for word to spread quickly throughout the community that the physician, the hospital, and the health care system can no longer be trusted. How many victims of domestic violence, how many drug addicts, how many HIV positive patients will refrain from seeking treatment because their trust has been breached? These are the issues that worry physicians.

We believe that there are public policy considerations which weigh very heavily in favour of protecting the trust between physician and patient, between the health care system and the community — policy considerations just as compelling as those which allow the Canada Customs and Revenue Agency to privilege information about personal income.

It has long been an acknowledged principle of government that some services are necessarily kept separate and confidential from other services. The most obvious example is income tax. We are told we can fill out our tax forms honestly and without fear of investigation or reprisal by any other government department. There are good public policy reasons for doing so.

Governments want people to be honest about reporting their income, both to create a level playing field among citizens and so that government can maximize its potential revenue from taxation. As a result, Canada Customs and Revenue Agency is allowed to operate within an information silo. The information provided by the taxpayer is protected because it is in the interest of government and public policy to privilege that information. Certainly if government can determine it is in the interest of public policy to shield the income tax information of Canadians, then a far more compelling case can be made for privileging their health information.

Beyond the concerns I have enumerated, we are also worried that no mention is made in the legislation about the duty of any secondary recipient of personal health information to protect the confidentiality of that information subsequently. We note that Privacy Commissioner Gary Dickson's letter to the Speaker of the legislature identifies that municipal police forces in this province are not bound by access to information and privacy constraints, that such laws as The Privacy Act and The Local Authority Freedom of Information and Protection of Privacy Act do not apply to municipal police forces.

Naturally physicians are extremely concerned about disclosing personal health information to police without statutory limits on the further use and disclosure of that information. This concern extends to the absence of any mention in this Bill of a monitoring mechanism or oversight body. There is no guarantee of reporting, no assurance that the rights and responsibilities mentioned previously will be guarded, no reason to have confidence that information shared by a physician or other heath care provider will be used only for the purposes that lie behind the government's rationale for this legislation. Clearly the legislature will have to close that critical gap. I must inform the committee that a physician cannot in good conscience release a patient's personal health information unless these concerns are resolved.

Our primary responsibility is the care of our patients. Effective care is founded on the trust our patients have in us that we will respect them as persons, that we will protect their privacy, that we will treat them equally, and that we will not breach the trust they have placed in us. The proposed legislation compromises those basic principles. We cannot support the legislation as currently written.

Saskatchewan's physicians remain committed to working with the members of this committee and the government to amend the legislation and to develop rules and regulations for its adoption which are congruent with our core values and which reflect the best interests of our patients.

I again thank the committee for this opportunity to present our concerns, and I look forward to future deliberations on the subject.

The Chair: — Thank you very, very much. Mr. Huyghebaert.

Mr. Huyghebaert: — Thank you, Mr. Chair. And thank you very much for the presentation, Doctor. I guess my question is very, very simple. Was there any consultation done between the Justice department of the government and the SMA before this Bill was drafted?

Ms. Doig: — Preparatory to its original presentation in the House, we were given an opportunity to view the draft but not invited to participate in any meaningful consultation.

The Chair: — I recognize Mr. Morgan.

Mr. Morgan: — Doctor, thank you for coming and thank you for your presentation. For us as legislatures, it's a matter of striking a fair balance between giving police as an effective tool as we possibly can and protecting the privacy and rights of patients and citizens. For us, we have to go through this once, and we're very mindful of the fact that the doctors and medical professionals have to live with the consequences of whatever decision we make on a long-term, if not permanent, basis. So we want to strike as careful or as an appropriate balance as we can.

The legislation as it is now drafted does not contemplate giving any more information other than the fact that a gunshot or a stab wound occurred. Obviously that will lead in an attendance by the police officer and the police officer wanting to interview your patient. And I don't know whether that fact alone, that the person presented with a stab wound or a gunshot, is any more invasive or any more troubling than reporting an STD which you're required under the statute to do. And I'm not sure that the benefits or the trade-off from a societal point of view are greatly different, or the provisions under the Criminal Code that exist now that require the medical profession to give blood samples that they've taken from somebody following a motor vehicle accident which are clearly only used for criminal prosecution.

And I don't know how, you know . . . When I look at what's already in place with regard to motor vehicle accidents, I look at the reporting that's there for STDs — you have to leave aside the issue with child abuse because you're preventing an ongoing offence or an ongoing series of actions — but with an STD or with a motor vehicle accident, I mean the reporting for an STD does not minimize that person going out and reinfecting somebody else. You know, nothing happens. The doctor makes whatever professional things . . . [inaudible] . . . welcome your comments.

Ms. Doig: — I hope that in my answer I will capture where you're trying to go with this, Mr. Morgan. I'm a little bit confused about some of the references.

To the issue of reporting of notifiable diseases, in that circumstance we are reporting not to the police. There is no requirement whatsoever to report to an authority other than another physician, another health trustee which is the medical officer of health. The medical officer of health and that person's employees in the public health domain have then certain responsibilities to society to look to issues of spread of disease and to look to issues of appropriate treatment of disease to ensure that we have indeed done what we should do when we diagnose those conditions. But that is not a situation where there's any reporting to a legal authority, and it is a reporting where the recipient of the information is also then subsequently governed by rules of privacy that prevent onward disclosure.

To the issue of, you know, does it really matter that we call the police to say, oh there's a person with a gunshot wound in

emergency, we do not call the police when there is a victim of sexual assault unless the victim specifically instructs us and indeed, as I said, in written consent allows us to do that. We don't notify. We don't notify on the victims of an accident, a highway accident. We don't notify the police about anything.

This Act is asking us to notify the police which then demands, I think, the logical expectation that we would keep the patient there until the police could arrive and come and do their first interview, yada yada. That would not be something that would be justifiable from a medical standpoint, and it turns us and the emergency room staff in effect into detainers of the personal freedom of the person to . . .

Mr. Morgan: — I don't think the Act contemplates that. The Act . . .

Ms. Doig: — The Act contemplates us notifying.

Mr. Morgan: — Yes. It contemplates the earliest time. And I don't think . . . and I would be troubled if I thought there was an inference in the Act that you were in any way responsible to detain, make the person available, or do anything else other than notify. You know, I don't and would not expect it to go beyond that, but I mean you know, somebody may put that interpretation on it.

Ms. Doig: — And you asked the question about body fluid samples after a motor vehicle accident. We do not perform any testing on body fluids or blood from an accident victim. If there's a requirement for testing for drug and alcohol for a legal purpose, then that information is not disclosed except with the appropriate subpoena authority or other instrument of the law.

Mr. Morgan: — Earlier today we heard from the College of Physicians and Surgeons. They took a somewhat different approach and indicated that they were supportive of the purpose of this Bill, suggested some alternatives, and indicated that their intention would be that the members of the College of Physicians and Surgeons would comply with and would generally support this. So I'm not sure who speaks for the physicians and surgeons. The college as their governing body or the SMA as . . . so on. And I guess that raises the next question. I don't know, you know, you said there's 2,000 members, so I guess I don't know, are you speaking for all 2,000 of them or as . . .

Ms. Doig: — When the SMA speaks, it speaks for its members, and our membership is voluntary. We regard ourselves as being the voice of Saskatchewan's physicians. The College of Physicians and Surgeons is our regulatory body. It can certainly make bylaws to govern our behaviour, and it can certainly discipline us when we don't behave according to the way that it has deemed appropriate.

Mr. Morgan: — I don't want to challenge your right to speak on behalf of them. But I guess you've indicated there's 2,000 members. Would that be the vast majority of doctors in the province, or is there some that don't belong?

Mr. Davies: — Ninety-five per cent.

Mr. Morgan: — Ninety-five. Okay.

Ms. Doig: — Thank you, sir.

Mr. Davies: — Membership is voluntary in the Saskatchewan Medical Association, unlike the College of Physicians and Surgeons, which is mandatory.

Mr. Morgan: — So exactly the same as the Law Society and the Canadian Bar Association.

Ms. Doig: — Exactly.

Mr. Morgan: — Thank you. I just wondered. I think this is probably . . .

The Chair: — Mr. Huyghebaert.

Mr. Huyghebaert: — Thank you again, Mr. Chair. I just have another quick question. In your comments on page 7, Doctor, you said that the SMA cannot support this legislation as currently written.

Ms. Doig: — Yes.

Mr. Huyghebaert: — What amendments or what proposal would you have as an inclusion or exclusion from this piece of legislation that would you put forward to us that would garner your support for the Bill?

Ms. Doig: — I think the obvious ones are the ones that I alluded to towards the end of my presentation. There need to be absolute safeguards on any kind of further disclosure of any information, assuming that information is to be disclosed.

We would prefer that we — and when I say we in this context, I do mean health care providers in general — not be the initiators of notification to the police. If there can be some way of drafting legislation that allows a compromised position, I would certainly look forward to co-operating with drafters on working on that wording. Off the top of my head, I can't give it to you tonight.

The Chair: — Mr. Iwanchuk.

Mr. Iwanchuk: — You did offer up where there are examples of reporting where there's a significant risk of harm to the patient or others. Could you provide an example, you know, just so that I could get a feel for what that means. What would that definition of that mean? What would that mean where . . . because you said that already does occur so . . .

Ms. Doig: — Right. There are situations where if we are aware that a person has expressed the intent to harm a specific individual, then we have an obligation to protect that individual as well. And there is case law, and Mr. Davies is flipping through his materials here to be able to speak to the specifics of it. But there are situations where, if there's an overwhelming risk of harm and we can identify who is at risk, we are permitted and indeed obliged to speak to that, not by virtue of statute but by virtue of case law within the common law.

Mr. Davies: — Certainly in recent memory, certainly in the last two years in this community, a physician was treating a person who he came, after hearing and reading news reports, to

understand to be the perpetrator of a series of violent attacks. And understanding the duty which is written in the code of ethics and which follows on case law, such as Tarasoff and Smith and Jones, with which Mr. Morgan will probably be familiar, a physician and a lawyer in fact are obliged to breach a confidential or fiduciary relationship if there is belief that there is a risk of harm to others. And this physician acted on that duty and actually went to police, and the evidence he provided was key in obtaining a conviction.

So it is something that physicians act on, but they act on it understanding their duty to society is that if there is a risk of harm outside of the patient-physician relationship, then they have an obligation to inform.

Mr. Iwanchuk: — Thank you.

The Chair: — Mr. Allchurch. Okay. Any further questions? Mr. Morgan.

Mr. Morgan: — I guess I appreciate the position and the delicacy that the SMA is putting forward, and I want you to know that we respect and value that. I don't know how we're going to come to an accommodation. We want very much to give the police a tool. We've had a number of unpleasant hypotheticals that were put forward to us, and you comment on them if you wish. And if you don't think it's beneficial, you're certainly not obliged.

One of them was the situation where a person is unconscious or unable to speak because of the nature of their injuries and would the doctor be entitled to infer consent? Or would the doctor, if they had a statutory obligation, just make the call? So that was the sort of the number one.

And then to take that one further, the patient that arrives unconscious or unable to speak and then expires without regaining consciousness. At what point do we say okay, you know, if they languish for an extended period of time, at what point should there be police involvement and at what point do they want to sort of . . . And if you want to comment on that one, please do.

Ms. Doig: — I think there are two important points to make, Mr. Morgan. One of them is the point that I already tried to make. The situation of the unconscious victim, the situation of the victim who is brought to emergency and expires, these are not people who are in complete isolation. They have next of kin. They have someone who can speak on their behalf, usually in relatively short order. I mean, how do these people get to the emergency department in the first place? They get there because someone has seen something happen and calls for an ambulance — so the act of notification.

What I think is happening in some of the hypotheticals you've been given is that there's a blinkered approach to sort of the circumstances around how a patient ends up in an emergency department or in a physician's clinic. They don't just fall out of the sky. Someone knows that those people have come. Someone may include in not only bringing them to emergency, but indeed calling the police. In any of those circumstances, someone else has made the decision to involve the police. It is not the physician or nurse or other health provider who is acting as the agent of the police and calling the police under a statutory obligation.

If someone comes to emergency unconscious, we make medical decisions in the absence of consent if there's no one to act as proxy. We don't make any other decisions. We don't give information to the news media. We don't give information to others who come seeking it until we have satisfied ourselves that we have the permission of the patient or the proxy to do that.

Mr. Morgan: — I don't have anything else, and I want to thank you, you know, that you've obviously given us some material we have to wrestle with, thank you.

Mr. Davies: — If I could just follow up briefly on Mr. Iwanchuk's question earlier when speaking about the duty to warn third parties, for example. It is when the physician identifies that there is a risk of future harm to the patient or to a third party that the physician may breach the seal of confidentiality.

And what we are considering and contemplating here is we may actually be asking physicians to place their patient in greater harm by drawing them to the attention of the police because you can be sure that, if they are the victim of a violent attack and it is known that they have been in contact with the police, that they are now at greater harm, at risk of greater harm. And so we're contemplating a physician doing that which is exactly the opposite of what that right to breach the seal is there for.

The Chair: — Any further questions members? Not seeing any, I want to thank you very much for taking your time to come in and give us your presentation. Thank you very much . . . [inaudible interjection] . . . Yes, we're going to take the rest of the night off. Thank you for that suggestion, Marcus. I muchly appreciate it.

With that, the committee will now stand adjourned until 1:30 tomorrow morning in room 8 in the Legislative Assembly.

[The committee adjourned at 20:36.]