



Third Session - Thirty-Fifth Legislature  
of the  
**Legislative Assembly of Manitoba**

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**STANDING COMMITTEE**

on

**LAW AMENDMENTS**

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39-40 Elizabeth II

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*Chairperson  
Mr. Jack Penner  
Constituency of Emerson*



**VOL. XLI No. 5 - 1 p.m., FRIDAY, JUNE 19, 1992**



**MANITOBA LEGISLATIVE ASSEMBLY**  
**Thirty-Fifth Legislature**

**Members, Constituencies and Political Affiliation**

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NAME	CONSTITUENCY	PARTY
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BARRETT, Becky	Wellington	NDP
CARSTAIRS, Sharon	River Heights	Liberal
CERILLI, Marianne	Radisson	NDP
CHEEMA, Guizar	The Maples	Liberal
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**LEGISLATIVE ASSEMBLY OF MANITOBA**  
**THE STANDING COMMITTEE ON LAW AMENDMENTS**  
**Friday, June 19, 1992**

**TIME – 1 p.m.**

**LOCATION – Winnipeg, Manitoba**

**CHAIRPERSON – Mr. Jack Penner (Emerson)**

**ATTENDANCE - 11 – QUORUM - 6**

*Members of the Committee present:*

Hon. Messrs. McCrae, Orchard

Messrs. Cheema, Chomiak, Edwards, Helwer,  
McAlpine, Neufeld, Penner, Rose, Ms.  
Wasylycia-Leis

**WITNESSES:**

**Bill 73—The Health Care Directives and  
Consequential Amendments Act**

Jaques Belik - Manitoba Medical Association

Anthony Dalmyn - Canadian Mental Health  
Association

Barbara Wiktorowicz - Alzheimer Society of  
Manitoba

John Oldham - Private Citizen

Gordon Mackintosh - Manitoba Association for  
Rights and Liberties

**Bill 75—The Health Services Insurance  
Amendment and Consequential Amendments  
Act**

Gordon Mackintosh - Manitoba Association for  
Rights and Liberties

Mary James - Private Citizen

Elizabeth Wood - Private Citizen

Pat Cherter - Private Citizen

**Written Presentation Submitted:**

Scott Cleghorn - Manitoba Medical Association

**MATTERS UNDER DISCUSSION:**

**Bill 71—The Retirement Plan Beneficiaries Act**

**Bill 73—The Health Care Directives and  
Consequential Amendments Act**

**Bill 75—The Health Services Insurance  
Amendment and Consequential Amendments  
Act**

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**Clerk of Committees (Ms. Patricia  
Chaychuk-Fitzpatrick):** Good afternoon. Will the  
Standing Committee on Law Amendments please  
come to order. We must proceed to elect a  
Chairperson. Are there any nominations?

**Hon. Donald Orchard (Minister of Health):** I  
would nominate the member for Emerson.

**Madam Clerk:** Mr. Penner has been nominated.  
Are there any other nominations? Seeing none, Mr.  
Penner, you are elected Chair.

**Mr. Chairperson:** Order, please. Will the  
Standing Committee on Law Amendments please  
come to order. This afternoon, the committee will  
be considering three bills: Bill 71, The Retirement  
Plan Beneficiaries Act; Bill 73, The Health Care  
Directives and Consequential Amendments Act;  
and Bill 75, The Health Services Insurance  
Amendment and Consequential Amendments Act.

\* (1320)

It is our custom to hear briefs before the  
consideration of the bill. What is the will of the  
committee? Agreed.

To date we have had 10 presenters registered to  
speak to the bills and I will read the names aloud.  
The list is Dr. Jaques Belik, Manitoba Medical  
Association; Mr. Bill Martin, Canadian Mental Health  
Association; Dr. A.J. Kirshen, private citizen; Ms.  
Barbara Wiktorowicz, the Alzheimer Society of  
Manitoba; Mr. John Oldham, private citizen; and Mr.  
Gordon Mackintosh, the Manitoba Association for  
Rights and Liberties.

For Bill 75, The Health Services Insurance  
Amendment and Consequential Amendments Act,  
there will be: Mr. Gordon Mackintosh, the Manitoba  
Association for Rights and Liberties; Ms. Mary  
James, private citizen; Ms. Elizabeth Wood, private  
citizen; Ms. Pat Cherter, private citizen.

There will be one written submission: Mr. Scott  
Cleghorn, Manitoba Medical Association.

At this time I will canvass the audience and ask  
that if there are any other persons present who are

interested in making a presentation to any of the bills that are before the committee, please contact the Clerk of Committees to have their names added to the list.

I would also ask any person requiring photocopies of their briefs to be made to also contract the Clerk. If there are any persons requiring photocopies of their bills, the Clerk will accommodate you.

I would also like to advise the committee that a written submission has been received for Bill 75, which I indicated. The submission is from Mr. Scott Cleghorn on behalf of the Manitoba Medical Association. This submission has already been distributed for the committee members.

Is there agreement from the committee to have this submission included in the committee Hansard for this meeting? Agreed and so ordered.

Did the committee wish to impose time limits on the presentations? The answer is no. There will be no time limits, although I would urge all presenters to be as brief as possible for the sake of allowing all presenters to make their presentations today. We thank you.

I would now call upon Dr. Jaques Belik, Manitoba Medical Association.

### **Bill 73—The Health Care Directives and Consequential Amendments Act**

**Dr. Jaques Belik (Manitoba Medical Association):** Honourable ministers, committee MLA members, ladies and gentlemen, on behalf of the MMA, we wish to thank very much this committee for giving us the opportunity of making a presentation on Bill 73, The proposed Health Care Directives and Consequential Amendments Act.

We wish to firstly say that we strongly support the passage of such legislation, and we must commend the work of the Minister of Justice (Mr. McCrae) and the Law Reform Commission of Manitoba in respect to the proposed legislation.

We wish, however, to address five important aspects of this present bill that we believe require amendments before it is passed into law. The five items that I will be referring to are first, requirement for a proxy; second, clarification of the physician's right to deny futile treatment when requested; third, consent for organ or tissue donation; fourth, recommendation for a witness; and fifth, requirement the directive be dated. I will now briefly address each of the issues.

Requirement for a proxy being the first one—this is certainly our primary concern as an association, and we believe the proposed legislation will be greatly strengthened by addressing the issue of a proxy decision maker. We must consider for that the need for a signed proxy decision maker under two different circumstances, the first one being, when an advance directive is available, and the second, when no such document is available or has been completed.

When an advance directive is available, according to the proposed bill, completion of an advance directive will theoretically reassure the individual or the maker of control over his or her medical decisions while incompetent.

In reality, we believe that is not so. Only two-thirds of directives, according to a recently published study in the United States, are indeed followed. The reasons for this lack of 100 percent compliance with directives is related to the fact that directives not always address the specific circumstances that the maker will find his or herself in when incompetent. Directives are often poorly written and often of ambiguous interpretation.

I wish to briefly take you through a medical example that illustrates our point. Consider a patient with early stages of Alzheimer's disease, who rights an advance directive with clear request for no life support if he or she becomes incompetent. Consider that individual, the same day that he or she has written that directive, suffers an accidental fall, is taken to the emergency room, and is found in need of ambulatory support because of a head concussion.

The physician in charge of the care of that patient will be faced with the advance directive on one hand, and perhaps with information from relatives, friends or others, that this individual, that very same day that he signed and completed his directive with the wording as I alluded to requesting no life support, was in fact planning on going on an around-the-world cruise next month or the following month, waiting for his grandson to be born and very much willing to partake in that happiness.

The physician would have to make a decision between following the directive as it reads—it would imply very clearly, no life support—even though that head concussion could have been an event for which the patient will recover within two or three days perhaps, or a little longer, and return to a stage that he or she apparently found to be comfortable

and worthwhile living, or elect to interpret the directive as meaning, most likely the individual meant if he or she were to become incompetent because of his disease, no life support should be provided when needed.

It is a typical scenario where the physician is left with interpreting directives at the mercy of not following what is stated, and therefore, be at risk of being sued later for not complying with the statement versus interpreting the directive, and therefore, perhaps defeating the whole purpose of the directive.

A proxy decision maker in a situation like that will very clearly be able to perhaps balance out the writings, and perhaps interpret the instructions in the directive, allowing the physician to then promote treatment according to what the patient would have wanted had he or she been allowed to express his or her wishes at that time.

The second scenario is when no directive is available. The reality of advance directives, living wills and durable powers of attorney in the United States is that only 15 percent of individuals have completed advance directives even though it is available in 49 states. We do not expect, in Canada, in Manitoba, any better figures than that. The reality of it is such that only a minority of individuals will take advantage of legislation such as ours that would allow them to complete advance directives or appoint proxy decision makers.

If an individual were not to have an advance directive and found to be in an incompetent state, then we would very much be in a situation similar to what we have nowadays, where physicians are often confronted with having to make decisions without quite knowing what is in the best interests of the patient, or having to rely on opinions and suggestions of family members without quite knowing how useful, or how much that represents truly the patient's perspective.

We very much propose, therefore, that the legislation should be amended for an adult person who lacks capacity to make a health care decision, that the decision be made to appoint a proxy defined as the first-named person or groups of persons from a list, with heading the list being the patient designated proxy, if there was one, followed by a nearest relative hierarchy, such as found in Section 2 of The Mental Health Act.

The second item of our presentation deals with futile treatment. Section 7 of Bill 73 precludes a

patient and a proxy decision maker from medical demands for treatment that patients, when competent, will not be able to make. As clear as that may sound, the reality is that, nowadays, many competent patients and their families often present demands for futile treatment.

In fact, in a recent study in the United States, it has been shown that at least 30 percent of surveyed individuals, when asked what sort of care they would like for themselves when found in a persistent vegetative state, irreversible condition associated with brain death or lack of cortical brain function, responded that they wish every possible life support applied to them.

We fear that if the act were to be passed as such, patients will nevertheless continue on requesting in their advance directives, futile treatments. Physicians, because of fear of future litigation, would grant either on a temporary or worse yet, in an indefinite way, treatment that would otherwise be medically inadequate or futile. We propose that this could be prevented by a clear and unambiguous statement in legislation denying the request for futile treatments.

\* (1330)

The third item of our presentation deals with organ donation. Presently, it is stated that the proxy under Section 14(c), does not have the right to consent for removal of tissue from the maker's body while leaving for transplantation purposes to another person.

The concern raised in regard to this section deals with the fact that, in regard to The Human Tissue Act, where it is clear that the nearest relative is allowed to consent for organ removal or tissue removal when death is inevitable, or has occurred, the reading in this section may lead others to interpret as, no organ donation is allowed, as opposed to what we believe this section is meant to address, that is to avoid or prevent proxy decision makers from authorizing inter vivos organ donation.

We propose that the act be amended to clearly identify that the prohibition is against inter vivos organ donation as opposed to any organ donation that could occur, as The Human Tissue Act already allows nearest relatives to authorize for.

The next item deals with recommendation for a witness. The bill, as presently stated, does not require an individual filling an advance directive to

provide for a witness that the directive was in good feal.

We believe that a witness would address two very important issues: No. 1, will reassure the physician or any other health care professional attending to the patient while incompetent, that individual was indeed competent when completing the advance directive; No. 2, would ensure that the directive had been completed, and therefore, would be made available when the maker was indeed held incompetent. We also believe that the bill should clearly state that no directive should be made under undue duress or influence.

The last item that I would like to address deals with the need for dating the advance directive. Here, we believe that by requiring the directive to be dated, the age eligibility could be confirmed, that indeed the individual when the directive was written was over the age of 16, as clearly stated in the act; that in case more than one directive was available, that the latest directive could be clearly identified; and to possibly ascertain competence based on historical evidence from the point of view of patients who do have progressive chronic diseases that lead to incapacitation of their memory and/or brain function, to be able to ascertain that, in fact, when the directive was written, that individual was competent and could understand what he or she clearly identify in that document as being his or her preference toward treatment.

With that, I thank the committee very much for listening to the presentation, and I am willing to address any questions or issues.

**Mr. Chairperson:** Thank you, Dr. Belik.

**Ms. Judy Wasylycia-Lels (St. Johns):** Mr. Chairperson, I would like to begin by thanking Dr. Belik on behalf of the Manitoba Medical Association for taking the time to be here this afternoon and presenting a very thorough brief with some clear recommendations for us to consider.

I have some questions, first a general one. Although there is no law presently before us, or in place in terms of living wills or advance directives or designated decision makers, obviously, many people have been doing it on their own, making living wills and putting out directives.

Is there enough of an occurrence of that, to date, for you to be able to tell us what the experience is here in Manitoba with such directives or living wills? Can you make any generalizations in terms of

language clarity of directive dilemmas for physicians, how they have been handled and so on?

**Mr. Belik:** Thanks for the question. We certainly do not have any data in that respect. You may know that perhaps. I am only aware of the Misericordia Hospital, for instance, that puts out a pamphlet with the advance directive form and makes it available to patients being admitted and encourages them in some sense to fill them out. All the other advance directives, or advance directives like documents that one may encounter in Manitoba, were all based on personal initiatives.

I clearly cannot give you an answer to how often they are appropriate or not. Based on the data coming from the United States, where advance directives have been in existence for a much longer period of time, it is clear that most advance directives are not clear enough when it comes to apply to the situation that the individual has found when incompetent. Meaning either the directive is too general and, therefore, it is very difficult to determine in that particular circumstance what the individual would have decided as being in his or her best interest, or the directive is so detailed that it becomes impossible to appropriately follow and, therefore, it is often dealt in a manner that does not completely address all rules and items listed in it.

**Ms. Wasylycia-Lels:** Mr. Chairperson, I appreciate that. It is the difficulty in being able to make any generalizations from the sporadic use of living wills or directives, and I appreciate the information you have been able to provide.

It is clear from your—or at least I am going to make the conclusion from your presentation—first of all that the MMA is strongly supportive of this initiative generally, but has some concerns; and then you clearly reference a couple of dilemmas for physicians.

It seems that they are on both ends of the spectrum. The dilemma of a directive that is maybe vague but however it clearly calls for no intervention, and the dilemma I think you are posing is that it means you could be prolonging or saving life but for that directive. Then on the other end you reference, I believe, the dilemma of a directive that very specifically calls for intervention of some sort that could very well be in the best judgment of the physician and the medical profession futile.

Certainly, that poses an interesting dilemma in our whole health care reform debate when we are talking about trying to put in place standards and

controls around medical intervention so that unnecessary futile procedures, drugs, interventions, tests and so on are not occurring. I will be interested to know how we sort through that dilemma.

I would like to ask you the question, specifically some advice in terms of how we amend this legislation or bring in some changes that will address those concerns. You reference the use of a proxy. You also talk about a clear statement, an unambiguous statement in terms of the futile intervention.

Could you tell us, have you looked through this bill? Have you got any specific areas where you think we should be looking at an amendment and precisely, how we could—perhaps we could do both in one fell swoop?

**Mr. Bellk:** We believe, for the very reasons that you alluded to before, that implementing the law in such a way where an individual will always have a proxy decision maker unless he or she specifically, in an advance directive, refuses either certain individuals or no one to represent him or her. That could be done by taking into account this list, a hierarchical list similar to what is already present in The Mental Health Act where a proxy is appointed according to a certain hierarchy.

We believe that advance directives in reality really are not helpful unless you as a physician have someone that you can discuss with, interpret the wording correctly and achieve a consensus as to what the individual really would like done under these circumstances.

I think an analogy can be drawn to an individual having a day in court without being allowed to speak and without having a defence lawyer to plead his case. It is really being left with the words without any interpretation to it, and most often the words are simply not enough.

In regard to the futile treatment that you alluded to, we believe physicians need to be clearly told that they are not obliged to provide futile treatment. We feel that the reality of Manitoba in 1990 is that even though all physicians should know that we are not obliged to provide futile treatment, there are perhaps as many as 100 patients in persistent vegetative states, or the likes, sitting in health care facilities across Manitoba because individuals feel uneasy about this continuing care that in most cases is clearly futile.

The reality nowadays is physicians should know better, but do not. Perhaps this act, with a sentence or two clearly stating that physicians ought not to provide futile treatment even if requested, will get a clear message and would not have to interpret an act.

**Ms. Wasylycia-Lels:** I have a couple of questions, the first going back to the first issue about ambiguous unclear statements or directives. You have talked about the proxy and the advance directives. I am wondering if you are suggesting that this law, this proposal be amended to ensure that doctors who make decisions to prolong or enhance life, when the directive is very ambiguous, unclear, not be held liable for that decision. Are you asking that kind of statement to be put in this legislative proposal?

**Mr. Bellk:** I guess we are mostly concerned with the concept of futile treatment in regard to ambiguity. I think, and this is my personal opinion, the act is clear enough in regard to protecting physicians for as long as he or she follows the directive to the best of his or her understanding. I do not think there is any ambiguity in that respect.

\* (1340)

Where I think there is ambiguity is on Section 7, that claims that a maker does not have while incompetent any more rights than while competent. Sure, one can interpret that to mean, well, if you know that a patient who is competent has no right to request anything, that it is futile, therefore, when he or she is incompetent, he or she does not have that right too. Why not say it clearly, I guess that is our point.

**Ms. Wasylycia-Lels:** Just a question on your recommendation pertaining to The Human Tissue Act. Your brief calls for consistency between the legislative proposal before us and The Human Tissue Act. I understand your presentation to mean that when there is a clear directive, that takes priority over The Human Tissue Act.

I am wondering if that is your understanding and that is your position, and secondly, if you still feel we need to have an amendment that addresses the different aspects of the two acts.

**Mr. Bellk:** What we were particularly concerned with is Section 14(c), where it reads the removal of tissue from the maker's body while living. We ourselves were not quite certain as to the meaning

of "while living". We interpreted that to mean inter vivos donation.

If that is not the case, we would strongly advise, or suggest, that the act be amended to allow proxy decision makers from having the same rights that The Human Tissue Act presently confers. Otherwise, we will be faced with a very unusual situation where, say, for instance, a spouse is the proxy decision maker of an individual. That spouse, as a proxy decision maker, cannot authorize, say a kidney organ donation, however, as a spouse, he or she can, and that does not quite make sense.

We feel that if The Human Tissue Act allows the nearest relative to confer the right for organ donation near that or after that, that the proxy should have the same right. If, in fact, Section 14(c) relates to inter vivos donation, that should be clearly spelled out.

Nowadays, we have a major problem retrieving enough organs for transplantation for patients who are in desperate need of it. We are afraid that if this legislation is passed with a rather obscure sentencing, physicians may again be deterred from approaching proxy decision makers and requesting organs based on their poor understanding or interpretation of this bill.

**Mr. Gulzar Cheema (The Maples):** Mr. Chairperson, I just want to thank Dr. Belik. I have known him for a long time. I worked with him, and he was my teacher at the Children's Hospital, so I know his capabilities as a teacher, physician and educator.

Certainly, I want to first point out to him that we did bring our bill, it was Bill 16. That was basically a draft from the Manitoba Law Reform Commission. The minister has brought Bill 73, which is almost a mirror image of that bill, but there are certain additions there. I just wanted to put that on record. I think it is very important.

We were disappointed, and I am not going to hold my disappointment here, because the Minister of Justice (Mr. McCrae) did not mention in his speech, not even once, that the bill was already in front of the House as a private members' bill. I feel obliged to mention that. I was disappointed.

Certainly, I want to address some of your concerns which we have discussed. The first one, your point of how we are going to teach Manitobans that we have a law. I think, as you have said, in the States, there are only 10 to 15 percent of people who are aware of their laws, but we have Manitoba

health, and I think through various ways, we can educate. It can be done through your offices or through the other professional agencies or through the Manitoba Health Services Commission. It can be notified. I do not think that is going to be the major issue.

My main concern here is, as you have said, in terms of your example of a patient who has Alzheimer's disease and signed a proxy this morning, and after a few hours, had a head injury. If it is not very clear in his health care directive what should be done, whether life support—what is life support? I think that can be qualified because still the health care providers will have to function under the broad area of health care guidelines. I do not think it is possible in any guidelines to put whether you can do a, b, c, d or f. I think it should be up to the judgment of the health care providers.

As you know, it is already being done, because the law is going to simply protect health care professionals, but these things are being done on a daily basis. That will address your second problem, what is the next issue of futile treatment.

It depends upon the definition of futile treatment. If you go across this province and talk to many other individuals, everyone has their own definition. I think it is going to be very risky, as a lawmaker, to put something into writing which is a futile and which is not.

I think it should be up to the judgment of the health care providers, as long as they are working within the framework of the guidelines, so we can certainly, at the committee stage, look into that to make sure that your concerns are met.

The third one, which I am really concerned about is there is a section in Section 22 of this bill, and we are going to ask the minister, when we are going clause by clause, to make sure to say that when the other one gets proxy, or the health care directive has acted in good faith according to the wishes expressed in the living will, and not contrary to the wishes of the person who has made the will, they should be protected, and that is not very clear. I think it needs to be very well defined because that could expose many of the concerns you have. It is so vague, and we want it to be very specific.

That was not even part of my bill when we brought that bill forward. I take your concerns very seriously, and our caucus will try to address some of them. I think, as you know, that this is the first bill of this kind in this country. When you are drafting



such a major part of the health care, or our living system, which actually should have come a long time ago, and we are talking about living wills, we take care of everything else, but we do not take care of our health.

I think we must say that at least the government has done that. The government has recognized a very major aspect. Certainly, with my disappointment, I will also say that the minister has done a good job in terms of at least taking the initiative. When we have this bill actually in a practical sense, we are going to have some difficulties. I think that probably it will be a process of coming back and having some more amendments done in the long term, but certainly your concern will be addressed at the committee stage.

I would like to know from you: What is the definition of futile treatment? How do you recommend that we should put in the wording in this bill?

**Mr. Bilok:** Perhaps if I left the impression that we wish the act or the bill to define life support or futile treatment, it is not quite our intention. What we feel is that it ought to be clearly spelled out that futile treatment ought not to be provided.

I quite agree with you that evidently the definition of futile treatment is a difficult one. It varies, and we physicians have a great deal of difficulty often addressing it in regard to specific patients, but we believe the broader message is important. If it is not clearly identified that physicians do not have the obligation to provide futile treatment simply because the individual requested in his or her directive, or because the proxy decision maker claims that he or she wanted it that way, that is the most important, I guess, battle to win.

The same holds true for life support. We do not believe that one ought to identify life support. The issue is truly interpreting directives, knowing what exactly the individual had in mind when the directives were written and how you as a physician, or health care professional, will best represent that individual by having simply the directive to follow.

**Mr. Cheema:** Mr. Chairperson, the other concern expressed by Dr. Belik was the amendments needed to make sure The Human Tissue Act is reflective of what it had been in the past and this law really excluded that part. That has been pointed out not only by you, but also by the Manitoba Association for Rights and Liberties. I think that

needs to be addressed in terms of making sure that the proxy does not exclude that part, so I think we should take that seriously.

The other recommendation is of a witness and I think that is very important and probably we can take care of that also. The date part, I was not aware of that, that the date part and the time was also missing. I think those are the important things. I am sure the minister's office has an excellent legal staff and they can advise us how to address those issues.

\* (1350)

I want to express my thanks that you have responded to our request initially. The MMA did just send me a note that you will be making a presentation, and certainly we will take your concern very seriously. Thank you.

**Hon. Donald Orchard (Minister of Health):** Dr. Belik, thank you for your presentation. Two points that I would like to make, we have recognized the concern over the issue you have mentioned of dating. It is the intention of the government this afternoon, to propose an amendment that would address that issue.

Secondly, in terms of the impact on The Human Tissue Act, Mr. Chairperson, with your concurrence, and of course with leave of the committee, which is required because we are not dealing with The Tissue Act here, and we have our little rules that we have to make sure we abide by. It would be the intention, with your permission and leave of the committee, that we would introduce the appropriate amendments to address the concern around The Tissue Act.

Dr. Belik, I have to say that I am quite intrigued with the futile treatment because that becomes quite an interesting issue. I see as difficulty, and I checked with legal counsel to ask whether there was in any existing statute, their knowledge of a definition around futile treatment. As you have indicated, and they have indicated, none exists.

I hate to be so crass, but I can see a real lawyers' wonderland created if we tried to put a definition around futile treatment. We could open up a whole Pandora's box. I understand what you are saying, sir, and I think that it is laudable that the MMA would be advancing the concern.

Can I ask you, sir, if it is possible within the MMA Ethics Committee, to attempt to get their minds around what might be definable as futile treatment, because I would make the conclusion that

experience will tell us whether this act will be used in reality of the coin reverse of what we intended—I think what the Law Reform Commission intended.

I think, if I can speak for the intention and presentation by yourselves and others who were consulted by the Law Reform Commission in making the report, the idea, I believe, was advanced that individuals should be able to empower health care professionals to not provide heroic measures. You have drawn the circumstance where they may use this act to empower every heroic treatment, futile treatment, as you have indicated.

I think experience will tell us whether the Manitoba circumstance would lead to much use of this new legislation in the latter case, at which time, the Legislature would be well-served by any advice you might be able to provide us on defining futile treatment, or whatever would be the appropriate phraseology, so that we might consider amendments at a future time.

I thank you for your presentation, sir.

**Mr. Belik:** You are welcome.

**Mr. Chairperson:** Do you want to respond, Dr. Belik?

**Mr. Belik:** Well, I guess you touch in a very difficult issue the concept of futile treatment. I would just like to make one quick comment.

The reality of medicine is, we are making a distinction between appropriate and futile treatment every day in medicine. When we decide to treat with treatment A versus treatment B, or not to provide treatment A, we are making that distinction. It is very hard when one has to put in words and has to clearly define, because it involves the whole concept of quality of life.

One could argue, for instance, that a patient in persistent vegetative state, after a two-month period, has been shown to have an irrecoverable condition. That patient will never recover brain function. However, some may argue, well, there is still quality of life in lying there and depending on others for every possible support. I think that is where the difficulty lies—how to define quality of life, more so, how to define futility of treatment because I think we all agree on futility of treatment concept. What we do not agree as physicians, is how good life has to be before we are willing to support it.

**Hon. James McCrae (Minister of Justice and Attorney General):** Mr. Chairperson, as a courtesy to the honourable member for The Maples (Mr.

Cheema), I think I can acknowledge that it would have been appropriate for me to recognize that the honourable member for The Maples recognizes a good idea when he sees one. He has the good sense to know a good initiative when he sees one. So indeed, the honourable member did have, before the Legislature, a private members' bill putting forward virtually the same thing that we are.

I say that, and I do not like to take away from what I have just said either, but I have to say that this government, and all of us, should perhaps recognize the wisdom of the government of Manitoba for reactivating the Law Reform Commission. The Law Reform Commission did an awful lot of work in this area and brought us to the point that we are today.

While I guess it is beefs and bouquets, I do acknowledge what the honourable member has done, but I also say that it was a wise government that reactivated the Law Reform Commission as well.

**Ms. Wasylycia-Lels:** I am not about to enter this discussion. I just thought of another question, that while Dr. Belik is with us, I would like to ask him. I am sure that there will be issues raised throughout this afternoon about whether or not there should be anything in legislation requiring a physician to determine if there is a directive.

I would like to ask Dr. Belik, based on the legislation as it now stands, how physicians, how the MMA, how individual physicians will interpret it in terms of, will they out of this immediately demand, or ask for a directive if one exists, or will they wait and see if one is produced voluntarily? What is your sense, and should we be looking at any changes in that regard?

**Mr. Belik:** I believe that physicians would certainly be very pleased to request a directive or inquire about a directive, but we are very pleased by the way the act reads in putting the onus on the individual in having to produce or make the advance directive known for it to be taken into consideration.

\* (1400)

We believe it would be very hard for any health care professional to conduct a thorough investigation to completely rule out a possibility that a directive has been written and it is in some safe box somewhere that ought to be read before decisions be made. We believe that it should be upon the individual to either carry in his or her

pocket, or identify whichever means that will allow that directive to become known if she or he were to be in need of.

**Mr. Cheema:** Mr. Chairperson, I just want one thing to be on the record, that I take the Minister of Justice's word very seriously because I think it is very important. We did have initiative initially, and certainly, you are the majority, and you are the government, and they have to at least recognize the importance.

Certainly one point I want to ask Dr. Belik, and probably he can explain to the committee, that right now even though it is not a part of law, these things, in fact, are being done. That differentiates us from the United States. If what is happening in Manitoba and Canada was happening in the United States, there will be a lot of lawyers who will be very rich. We have a very different approach to the health care system. This will give protection to the physicians, and also will give dignity back to the patient.

The other issue which is quite important is our elderly population, which you know, when their family members move away, it becomes very tough for the health care provider to make decisions. If you have something in writing that will not only give security for the health care provider or institution, plus it will also give comfort to the family members who are not, at that time, in a part of the community. They may be somewhere else. We have come across those problems, and those are the practical issues. I am sure you do agree with them.

**Mr. Chairperson:** Thank you very much, Dr. Belik. Did you want to respond to that?

**Mr. Belik:** No, I just wish to thank you for the comments. I fully agree with what you say.

**Mr. Chairperson:** Thank you very much for your presentation.

Before we proceed, I want to relate an incident that happened on our farm to the committee. We do have a C.B. radio on our farm. We operate most of our equipment by radio, at least we communicate by radio, and there is such a thing as skip, which is interference with the two people who talk, and it comes from outside.

I would suggest to committee members that I am encountering a bit of skip in the committee at this time. I would suggest that we turn down the squelch just a wee bit and maybe the two people who should be communicating can be heard. Thank you very much.

I will now call on Mr. Anthony Dalmyn, who will be replacing Mr. Bill Martin, of the Canadian Mental Health Association to come forward please.

**Mr. Anthony Dalmyn (Canadian Mental Health Association):** Mr. Chairperson, there is no written presentation for the Canadian Mental Health Association. My presentation is devoted primarily to commending the government as well as the member for The Maples (Mr. Cheema) for his private members' bill and indeed the previous government, the current opposition, for its attitude on Bill 73.

Bill 73 is a good piece of legislation. It impacts on The Mental Health Act in a way that is slightly different than the Law Reform Commission recommended, but the Canadian Mental Health Association supports the way in which this legislation operates.

The members of the committee will remember previous sessions on The Mental Health Act, particularly the sessions last summer on Bill 5. Bill 5 left a loose end.

When you consider the situation of a person who goes to a psychiatric facility, The Mental Health Act provides that person has the right, while competent, to consent to treatment or not to consent to treatment or refuse treatment. The act provides that if the person is not competent and is found to be not competent upon a proper assessment, then treatment decisions will be made by the nearest relative or by the Public Trustee.

The introduction of nearest relative was one of the innovations and reforms of Bill 5 last year. The committee will recall that there was a concern by certain segments of the population of health care consumers that that was not good enough. Particularly, the victims of family abuse who experience ongoing psychiatric problems were repelled by the possibility that a family member who had contributed to their situation could be the person designated by law to make treatment decisions for them.

That population, with the support of the Canadian Mental Health Association, asked very strongly for the right to appoint proxies. The minister made a commitment to study the situation—I am referring to the Minister of Health (Mr. Orchard)—upon receipt of the Law Reform Commission's report. The minister has kept his word.

Section 28 allows a mental health consumer to appoint a proxy to make treatment decisions and

gives the proxy precedence over the nearest relative or the Public Trustee. That is a good reform. The government and all other interested parties are to be commended for taking the legislation this far, and we urge you to take the legislation to completion on that issue.

We have a question of clarity of language. The Health Care Directives Act at large says that a health care consumer can have a directive, which can simply be a piece of paper, which gives directions for health care, or the directive can add the appointment of a proxy.

The ordinary health care consumer can simply go on the basis of a card or a piece of paper. That is a situation that has been before the court. For example, a number of people of the Jehovah's Witnesses faith carry wallet cards refusing certain types of treatment involving blood products.

This is obviously not desirable in the context of The Mental Health Act. The legislation operates on the basis that there is always a decision maker to stand in the shoes of the incompetent patient, whether it be a proxy, a nearest relative or the Public Trustee.

Nevertheless, as The Mental Health Act now reads in subsection 24.1(3), a consent giver, be it proxy, once these amendments are through, or a nearest relative or the Public Trustee, should attempt to determine the known wishes of the patient while competent. A patient who has had previous medical treatment may have established a suitable or successful pattern of practice that they would readily consent to, to the exclusion of others. They would want to consent to some things, and not others. They would make their wishes known.

I suppose if there is a mixed message in the legislation, it is this. Section 3 of Bill 73 says The Mental Health Act prevails. We then have The Mental Health Act amendments which say that, a proxy appointed under The Health Care Directives Act is recognized, which carries the implication, perhaps, that a directive has no status.

I think if it came to court, but it should not have to come to court if the legislation is sufficiently clear, a directive would express the patient's competent wishes, and should be recognized for the purposes of 24.1(3).

I have had the privilege of a discussion with the Attorney General's staff, and I think I have made the point to them, and I make it to this committee. Perhaps a court will say, a directive, obviously, is a

good expression of competent wishes for the purposes of 24.1(3). There is a chance it is not.

In any event, this legislation is to be read, not necessarily by lawyers, judges and courts, but by the public, by practising physicians and psychiatrists. It should be as clear as possible. It should be proactive. It should be crystal clear that in considering the prior competent wishes of an individual for the purpose of The Mental Health Act, any directive that the person made, should be given due weight and consideration.

The other area of comment on The Mental Health Act reforms,—let me stop there. It is a comment on a section within the main body of The Health Care Directives Act which has some impact on mental health practice.

Section 21 of Bill 73 will provide that no person is required to inquire into the existence of a directive or of revocation of a directive. The Law Reform Commission's report and draft bill are somewhat ambivalent on this. Recommendation 33 of the Law Reform Commission had said that the onus should be on a person or patient who is the maker of a directive.

We then move through the Law Reform Commission report and we see them shifting from a wording that says, the onus is on the patient, to, there is no onus on the health care provider. There was a related recommendation in the Law Reform Commission's report saying that no health care provider can be liable for ignoring a directive they know nothing about, which has been carried forward into paragraph 22(b) of Bill 73.

\* (1410)

The Canadian Mental Health Association has no difficulty with the idea that a patient bears the ultimate onus of communicating the contents of a directive or the appointment of a proxy to the physician or health care provider who is attending them.

The Canadian Mental Health Association has no problem with paragraph 22(b) that says, nobody is liable for not acting on something that they know nothing about. The question is the gap in there. When a disabled person comes into a psychiatric facility, they communicate some things, they do not communicate others. The person may have a file. There may be a record of who the proxy is. There may be all sorts of indications of prior competent

wishes. There is material right there that can be readily investigated.

One would suggest and expect in this province, that the ethical and legal situation is that a physician would make reasonable inquiries. The previous witness before this committee, Dr. Belik, said, the medical profession collectively, ethically and legally has no problem with the idea of making reasonable inquiries, but does not want to be propelled into investigating to the nth degree.

My comment is that there is a problem in the wording of Section 21. Somewhere along the way, the original intent of the Law Reform Commission, which was that there is no onus on the maker, has been turned into an idea that there is a statement in legislation that nobody is expected to inquire. There should be reasonable inquiry.

I do not know whether one would want to legislate, as they do in the draft bills in Ontario, that there is a positive legal obligation on the physician to inquire. I think the reasonable protection of the physician is accomplished simply by deleting 21 and resting on 22(b) and on sound clinical practice, and on the general law that applies to health care, or alternately, by going back to the original recommendation of the commission saying, the onus is on the maker to communicate their directive.

I say this has implications in mental health. I realize that my comments affect health care at large, but I believe this could be the source of particular problems in psychiatric facilities. As some members of this committee know, the Canadian Mental Health Association operates an advocacy program through its Winnipeg region. A number of patients report that when they come in a crisis, obviously, their competency is somewhat compromised, and sometimes, they do not get full respect, their files are not read, and there have been problems that have emerged. So the Canadian Mental Health Association has some concern on this recommendation and suggest it could be tightened up.

Overall, however, the sound coming from this podium is definitely applause. Thank you, Mr. Chairperson.

**Ms. Wasylcia-Lels:** I would like to begin by thanking Mr. Dalmyn on behalf of the Canadian Mental Health Association for taking time to appear before this committee and to give us some reaction to Bill 73.

For the record, I think it should be clearly indicated or reiterated, that the Canadian Mental Health Association strongly supports this legislation, and indeed, has fought long and hard for this concept to be entrenched in law over a number of years. We all recall the debate around Bill 5, amendments to The Mental Health Act.

I have questions on the two points that you have raised, Mr. Dalmyn. First, you raised the general discrepancy between treatment of those who fall under the health care system generally, and those who fall under the mental health care system and mental health legislation. My question is, what is the best way to correct that? The MMA has suggested that, I believe, that we change the legislation to require, in all cases of directives, the identification of a proxy.

I presume that would be one way to correct the imbalance so that in both systems a proxy is required, or the alternative suggestion would be to eliminate, and I guess we would have to then amend The Mental Health Act, the special requirement in terms of going to the nearest relative and disregarding the directive. I would like some advice in terms of how best to deal with that discrepancy.

**Mr. Dalmyn:** Mr. Chairperson, I agree that Bill 73 leaves some differences between the rights of people in general health care and the rights of people in psychiatric facilities. I do not view that distinction as necessarily being bad. I suppose it is conceivable that some day, there would be a question of discrimination against people on the basis of their mental status, but as I read the operation of this legislation, the operative differences are not significant, and perhaps are justifiable by the problems that people are dealing with.

When we look at the MMA's recommendation, I emphasize the MMA, the previous witness before this committee was suggesting that The Health Care Directives Act, the main act, should be amended to say that if somebody does not have a proxy, then their nearest relative will give consent on their behalf. I suppose it is not within the mandate of my organization to comment on that. As a private citizen, I would say I agree with the Law Reform Commission, I agree with the Attorney General (Mr. McCrae), and I agree with the bill as it stands.

It is one thing to allow an individual to have a health care directive or to appoint a proxy to project their own wishes into the future. It is something else

to impose treatment decisions by your nearest relative, regardless of the level of wisdom of that relative or your degree of estrangement from that relative upon everybody. That recommendation is not consistent with the philosophy of the Law Reform Commission's report or the act. I do not think that can be accepted without very serious study.

The question of the rules for consent to health care on behalf of incompetent people who do not choose to have proxies is a different topic, and it is not addressed in Bill 73, and it should not be picked up.

The other side of it, should we begin serious tinkering with The Mental Health Act to just say that proxies will be the rule in The Mental Health Act, that does not work either simply because of the number of people who do not have proxies. I believe Bill 73 makes a good reconciliation between giving people under The Mental Health Act better rights, the right to have a proxy, while preserving the regime that allows proper treatment decisions in the best interests of patients under The Mental Health Act.

**Ms. Wasylycia-Lels:** My other question has to do with your comments about whether or not inquiries about whether a directive exists or not should be required or not and how it should be handled. I had the same concern that you mentioned, Mr. Dalmyn, about 21. It would appear, and I believe this is the essence of your remarks on this matter, that by virtue of it being in here and the way it is worded that in fact people will conclude, individuals will conclude, organizations will conclude that in fact we should go out of our way not to inquire about whether or not a directive exists. It would seem that the best way to handle this point would be to actually delete 21.

I am wondering if—certainly we will pursue this later—the Minister of Health has considered that or not and, if that is out of the question, if the minister and the government refuse to consider deleting Section 21, is there another alternative for ensuring that we do not go the opposite of the intentions under this bill.

**Mr. Dalmyn:** The problem that I tried to describe with Section 21 is that it seems to depart from sound clinical practice. Sound clinical practice obviously is to make inquiries, and Section 21 says you do not have to make inquiries. I am suggesting either that 21 can be dispensed with or that the wording be changed simply to say that the maker of a proxy has

the onus of communicating the proxy. That read in conjunction with what already stands as paragraph (b) in Section 22 would send the correct message and would provide proper legal protection to health care providers who act in good faith.

**Ms. Wasylycia-Lels:** Just a clarification, just so I understand, because I may have misunderstood you before, you are not suggesting the deletion of 21, but a change in wording in terms of the onus being put on the proxy.

**Mr. Dalmyn:** I believe either would have the same effect. A positive amendment may be more clear in sending the right message to providers of health care and to consumers of health care.

**Mr. Cheema:** Mr. Chairperson, I first wanted to express our thanks to Tony Dalmyn for coming and making a presentation. Certainly we have received communication from Bill Martin, Executive Director, and your association, supporting Bill 16 and now Bill 73.

\* (1420)

Your one concern of Section 21—actually, when the bill was being drafted we had a concern. How do you enforce health care providers in institutions to explain to each and every patient that they have this right, explain to them and then you are putting the onus all on the health care professional. We have a concern that it is ideal if we could do that but, to do that, to achieve what you are asking, we have to basically amend then The Health Services Commission Act, because that way we have to enforce the health care providers to make sure they are explaining to all the patients. I think it will become very difficult, become almost impossible.

The other problem is going to be if a patient is visiting two physicians or two hospitals, two personal care homes, two other facilities, how do you reinforce those things? It becomes very tough.

I think it should be up to the patient to make arrangements to ask for and, as the education can be done very easily through the Health Services Commission and not sort of forcing them to do, that is what you have to do, but just educating them and giving them all the options. Just to ask everything the health care professional is to follow, I think is going to become impossible.

Certainly your intentions and the associations' intentions are quite right, but it may not be possible. I just want to explain to you that we also discussed this when we were drafting Bill 16.

**Ms. Wasylycia-Lels:** I just need to seek a clarification around the issues pertaining to 21. I guess I am having some trouble understanding if we did change 21, and make a positive statement that the maker of a proxy has the onus to indicate that a directive exists, how that is any more likely to lead to reasonable inquiry than existing wording of 21.

**Mr. Dalmyn:** Mr. Chairperson, the answer is that 21, as presently worded, says there is to be no inquiry. That removes, one would believe, the obligation to inquire. We delete or modify 21 by putting the onus on the maker. We do not impose an indefinite or intolerable burden on health care providers to make inquiry.

We also make it clear that the fundamental message of the legislation is that the maker cannot hide his light under a bushel basket. You cannot leave your directive in a back drawer, in a safety deposit box, and expect a health care provider to act on it when you are brought in bleeding from a car accident. It sends the right message without putting an improper burden on clinical practitioners, and the common law will enter into it.

The common law will require a practitioner to get whatever points of history are relevant in dealing with that patient. Depending on the nature of the crisis, if you have no time and there is no directive known to you, you do what you have to do. If you have time, and you have a minute or two, where you are dealing with a patient who has some ability to express his or her wishes, get some information, do what is reasonable.

The common law does not put heavy burdens on doctors, and I simply suggest that the deletion, or modification of 21 would leave the law consistent with medical ethics, sound medical practice and the common law as to doctor's obligations.

**Mr. Dave Chomiak (Kildonan):** Mr. Chairperson, so if I can conclude what you are stating, Mr. Dalmyn, the providing of this Section 21 actually in fact may affect common law to the extent that, in the normal inquiries a doctor or health care professional makes, they will not be required to even make a reasonable inquiry about a proxy or about a directive. Is that correct?

**Mr. Dalmyn:** Mr. Chairperson, the member has put the concern accurately. Section 21 goes beyond reasonable protection of practitioners and begins to modify the standard of care that would exist in common law, yes.

**Mr. Chairperson:** Thank you, Mr. Dalmyn. The next presenter before the committee will be Dr. A. J. Kirshen, private citizen. Dr. Kirshen, will you please come forward. Is Dr. Kirshen in the room? If not, then we will proceed to the next presenter, Ms. Barbara Wiktorowicz, the Alzheimer Society of Manitoba. Am I pronouncing your name correctly?

**Ms. Barbara Wiktorowicz (Alzheimer Society of Manitoba):** It is Vict-o-ro-vich.

**Mr. Chairperson:** Vict-o-ro-vich. Will you proceed, Ms. Wiktorowicz.

**Ms. Wiktorowicz:** Thanks very much for giving us this opportunity to make a presentation on this legislation. With me today is Deloree McCallum, who is an active volunteer at the Alzheimer Society and someone who has experienced Alzheimer's disease in her family and has worked on our committee that has reviewed this legislation. If there are further questions, she will be here to help me respond to them.

Overall, the Alzheimer Society is very supportive of this legislation. We favour a broader approach to the health care directives which is grounded in the principle of self-determination. As you know, Alzheimer's disease is in fact a terminal disease and has a long-term progressive nature. It can go up to 20 years. This distinguishes it from any other illnesses and sudden catastrophic accidents.

It is very important, then, that in considering the opportunity that an individual who has been told that they have Alzheimer's disease, will have some time and opportunity to consider whether they want to refuse treatment, or choose one treatment over another in their future. Our overall support is favourable, and we commend the government for bringing this legislation through.

We have a couple of concerns in a general overriding issue. Our concerns are, one, is the limitation to the proxy in Section 14 where the proxy cannot give consent to drug trials or experimental treatments. Since research is developing in the area of treating Alzheimer's disease, and it is of primary interest to those who are afflicted and their caregivers, we believe that it is a little bit too narrow to limit the proxy's ability in this area.

I guess, if there cannot be any amendments here, we would take a very active role with our families in terms of educating the individual with Alzheimer's disease that this is something that has to be placed into their health care directives. As Dr. Belik

indicated earlier, only a small proportion of people will actually complete this health care directive. We believe that this limitation should not necessarily exist.

The second one is the relationship between the proxy and the committee. The committee, which is the legal person who can be appointed as private trustee—the Alzheimer Society wishes to express concern regarding potential conflict between the proxy and the committee which is not addressed to our satisfaction in the legislation. The act does not exclude the private committee and the health care proxy from being one and the same person. However, if the private committee and the health care proxy are two separate individuals, the act does not provide for resolving conflict between these two in situations which involve financial costs.

If the health care proxy makes a medical treatment decision which involves cost to the makers such as the health care aide, dentures, wheelchairs, hearing aids and so on, the private committee would necessarily be involved, but may not agree with the decision. We can foresee that there may be conflicts and some sort of mechanism perhaps should be put in place to settle a dispute like that.

Our overriding concern is still the issue that unless an individual has completed the health care directive or appointed a health care proxy, it still leaves the family, once the disease progresses and the individual is incompetent, in sort of a legal limbo. The diagnosis of Alzheimer's disease may or may not be made while the person is still considered competent. The early symptoms of the disease are very insidious. The diagnosis is not made easily, and often, the dementing person does not understand or agree to medical consultation.

Many families make application for private committee, but few known to us, are extended the specific authority concerning the individual's medical treatment. Usually this is excluded and the committee is just to govern decisions around a person's property, not personal decisions.

\* (1430)

We strongly suggest that this act address this issue. In the case where the person is judged to be incompetent as a result of Alzheimer's disease or related dementia, and there is not appointed a health care proxy, that an opportunity be provided for an individual to apply to become a health care proxy, whether under the health care act, or through

another appropriate section of The Mental Health Act. Such inclusion would strengthen the case for concerned and caring family members who require some authority for medical treatment decisions.

Thank you very much. That is my presentation.

**Mr. Chairperson:** Any questions?

(Mr. Bob Rose, Acting Chairperson, in the Chair)

**Mr. Cheema:** Mr. Acting Chairperson, I first of all, would like to express sincere thanks again to the presenter. I just want to go back to her last concern in terms of—can she again explain to me how she feels that the—as I am sure she has read the whole thing in terms of the proxy and the health care directive can be changed by the person at any time, and the competency has to be decided upon by the health care providers. That definition is very broad. One person could be competent for a part of the daily affairs. He or she may be competent for financial affairs or may not be in some other aspect. I think this is quite an open definition.

I think that may address that part, as long as that is being very well explained and the health care directive and the proxy knows about that, but a lot of education has to be done.

As you have pointed out, the main concern is whether people are going to know these things exist. That was our concern also but, certainly, the Health Services Commission can do that. I mean, the physicians have to get involved; more health care providers have to get more involved; the hospital has to make a policy in terms of letting people know that such and such a law exists.

I just want to ask you whether that part of the definition of competency would address the issue you have raised.

**Ms. Wiktorowicz:** Well, still I believe not completely, because the issue is more that there still is a gap left for those individuals who do not, while they are competent, sign a health care proxy or a health care directive.

I guess it may really extend beyond this legislation. I think we feel that there has to be some legal authority given to a family member or someone either that the person appoints or that a court appoints that becomes a person who has a legal authority to make decisions about the medical care, even though the individual has never signed a health care proxy form.

I agree that the society will become involved in educating families and, as you said, hospitals, and



physicians maybe can be active in that, but we know that many people do not take advantage of that opportunity, so we think there still will be a gap there.

**Mr. Cheema:** Mr. Acting Chairperson, again, I am sure you are aware that the Public Trustee could get involved in the example you have given. In cases where you do not have a family member or the patient incapacitated or the health care providers are concerned that care is not being provided according to the wishes of the patient, the Public Trustee can get involved and that could address your other issue.

Also, the other aspect, which I pointed out at the earlier stage of the presentation, was that still these things are going on, that the two physicians or the three physicians or the two health care providers could get together with the family and discuss all the options. Those things are being done but, to make it legal, still the Public Trustee in my opinion can do the same thing as you are asking.

**Ms. Wiktorowicz:** The Public Trustee would have to be appointed for that individual, and right now it is usually a kind of a gap in the law. In my conversations with physicians they act as if there is a proxy usually with the closest family member. I mean they see the family is well intentioned and that is who they work with so, in effect, that is what happens.

Family members have expressed concerns to us saying, well, we are really in a vacuum. If they did not want to pay attention to what we suggested be taken seriously in terms of drug treatments that help, there is no onus on health care providers to do that at present. There is not a vehicle in terms of a family member. Even if the family member has been appointed a committee, that still gives them only the right to make decisions about property.

**Mr. Cheema:** Mr. Acting Chairperson, the first concern the president had was whether participation in drug treatment or experimental treatment has to be a part of the proxy. If that can be given in terms of the will, it can be explained what that includes and these are the basic guidelines how the patient is going to be treated. I think that can be corrected. Certainly we can ask the legal opinion whether that is going to be viable in the long run, but there I find some concern. For example, you do not want somebody to be tried on experimental drugs, or some treatment which may or may not be a well-accepted, normal pattern of practice in a general way.

I think that is one concern. That may be the reason that when the bill was being drafted, they did not include that. I am sure individuals will be concerned. If you are talking about certain groups of patients, it may be applicable but, when we are making a law for everyone else, then I think it becomes very difficult. I just wanted to hear from you what you think.

**Ms. Wiktorowicz:** Mr. Acting Chairperson, I think I would assume that if the individual, though, appointed a health care proxy, that they have confidence in that person's decisions about their own health care. That is why I am not sure why a health care proxy could not, without some kind of advance writing in the directive, make decisions on this medical research area.

Alzheimer's would be one example, but there are other diseases that there are experimental treatments, and it may be very much, to the person who is suffering with the condition, to their benefit to receive some of these treatments. If they had not had the forethought to write it into their directive, but they had appointed a health care proxy, it seems like there is a contradiction there that I do not think is really necessary.

**Mr. Cheema:** The final comment on the same issue again—as you know, under our health care, all the health care provisions, the treatment methods, the drugs and everything else have to be approved by the drug agency and Manitoba Health under the Manitoba health act. If that act is not going to cover the medical treatment which you are asking the drug trials and experimental drugs, that could cause a major concern in terms of the cost and also a major concern in terms of the legal liabilities for those drugs which are being simply tried. I just wanted to express that may not be possible.

If it was just for one section of the community, then one can have a good look at the whole thing, but when you are talking about the whole spectrum of patients and community, it may not be certainly practical at this stage, but we should have a look at that in the future. That is my own concern, and practical problem which we could have if we put that kind of wording into the law.

**Ms. Wiktorowicz:** Mr. Acting Chairperson, yes, I agree that some limitation might be important to have in there in terms of only drugs that have been approved and that, so that seems fair. I think it could be maybe somewhat extended from what it is right now.

**The Acting Chairperson (Mr. Rose):** Thank you. Are there any other questions of the presenter? If not, I would like to thank Ms. Wiktorowicz for her presentation.

The next presenter, Mr. John Oldham, private citizen.

**Mr. John Oldham (Private Citizen):** Ladies and gentlemen, the bad news is that I think this is the worst time of the day to be listening to any speaker, let alone a preacher. The good news is that the document I have before you, while it looks lengthy as most of my sermons, I will not be reading it all.

I am honoured to be here and to be sharing in the process of this nation and this province where the public can be consulted in the decision making, whether some of us have tented out on the peace village or some of us present here in this room.

I am here as a private citizen as it says, but I expect that I represent a significant number of people in the church and other communities of spiritual and religious traditions in the interfaith world. I present, as a minister of the United Church of Canada for the last 23 years, who has learned a great deal from the ill and from the dying in care institutions and in their private homes.

\* (1440)

I write as a former member of the Manitoba Hospice board, who had done preparation for the board in terms of the Law Reform Commission's document. I write as a religious consultant and column writer for the Right to Die Society's bimonthly journal called Last Rights, and I am a member of that society.

I enclose for your consideration a statement which I will refer to later that I made on CBC commentary the day after Nancy B. died. I assume that you are aware that the polls reveal that nearly 80 percent of Canadians are in favour of euthanasia or doctor-assisted suicide when it is the stated wish written instruction of the patient.

I recognize treatment directive document to which we address today will go a far way to honour the wishes of the vast majority of Canadians, and have the effect of beckoning the Criminal Code to catch up with the wishes and the practice of the medical community and the general public to facilitate a good death.

I wish to affirm the position of the Law Reform Commission in Bill 73 of the right of an adult, in this case now you have it at 16—a person of a sane mind

to self-determination. I am one who will continue to be the advocate of those who wish to exercise either their right to live or their right to die. I support the naming of a proxy as long as there is some safeguard, and there seems to be in the legislation, that that person is not attempting to make selfish gain by serving in that function.

I encourage the committee to study and utilize the material from the booklet and treatment directive called Let me Decide, prepared by Dr. Molloy of Hamilton. It is here in my hand and your Clerk has it for file. They are available at local bookstores for \$5 or less, and I am quite happy to pass this one on to anyone here. I understand that 25,000 copies are being circulated to Ontario doctors and others in the health care field in Ontario where this issue is currently under review as well.

This treatment directive uses medical terms and lists various instructions in detail and allows for update and review. Too many so-called living wills are so general, as Dr. Belik as already testified, or so brief, that they are of little precise guidance for the family or the medical community or for the proxy.

I wish to make available to you as well, as part of my submission, a recent and excellent article from the June 1992—this is hot stuff, the book is just off the press this spring—this issue, from the June Canadian Medical Association Journal provided to me by one of the doctors here in the city to whom I am grateful. It is entitled Family Physicians Attitudes Toward Advance Directives, and it is probably the most current information that can guide us in any modifications to the legislation. Written by a Dr. Hughes and Dr. Singer of the University of Toronto, the survey strongly favoured Bill 73 as it is proposed, a directive comprising both instruction from the patient as well as a proxy component.

The issue of how to encourage people to fill out directives is a vital one. Might a process be used through the Manitoba Medical Association that patients are given a copy and invited to fill it out? As well, all people admitted to hospital might be given a copy if they have not already completed one. Perhaps, if we are visionary, even in a few years time our driver's licence might have a summary type of directive just as it now has instructions regarding organ and body donations.

In summary, I have been impressed with the commitment of the health care community to honour the wishes of the patients and their families if the patient is unable to communicate. I have had the

opportunity of being involved in caring for those whose wishes have been respected, either to go home and die in the dignity of their living room, or to have treatment suspended while remaining in a hospital bed.

Recently, a senior who had chronic long-term pain, heart disease and other illness had made it clear to me, his pastor, that he wanted to die. He dictated a two-line statement to me that he wanted to die and he stated, I wish to die naturally, I do not want intravenous.

A thorough assessment and consultation was done with the hospital community, the doctors, the nurses, the family. He chose not to eat and it took him three weeks to die. We shared the 23 Psalm together and his one regret was that it was taking him too long to die. I hope that some day, some day soon we can honour those kinds of wishes with greater dignity and respect than to let a person starve to death in a hospital bed.

The point however is that a two-line statement witnessed by me, his minister, served as a treatment directive that was honoured and followed by the health care team at the Grace Hospital.

I sit by bedsides of people tied to tubes and machines and I know that it is not how they want to exist. I visit those severely brain damaged for over a year and see the strain on family, and I know that the wishes of the patient were not to continue in a vegetable state. The patient indeed had verbally told his son his wish but it was never written down.

My hope and prayer is that your work in this legislation will make it legally and morally binding to follow the wishes and the instructions of patients as they exercise both their right to live, and their right to die.

I commend you for your work and some closing remarks or some additional remarks that came to me today, as I read over the legislation, I am aware that there are no sections related to the format or to the type of treatment directive that would be suitable or recognized except for Section 11, in the document where it says the Lieutenant-Governor-in-Council may by regulation prescribe a form of directive but the use of such a form is not mandatory.

In light of Dr. Belik's earlier comments about the variety of written documents and the usefulness or lack of some of them, there might some wisdom in an implementation committee consulting with the different Winnipeg hospital ethics committees to prepare a basic directive that would have the

approval of the authorities, to serve at least as a guideline for people asking what can I fill out. I do not see that guideline included in the legislation. I would hope that there is some supplementary material that you have from the reform commission or other sources.

The enclosed one by Dr. Molloy, which I will refer to in a moment, might be augmented by statements from other directives currently being tested in Manitoba. One would not want to have a directive that gets too long or complex as it might frighten some people from filling it out, as Dr. Belik has suggested.

Number two, in chatting with hospital chaplains and social workers this week preparing for today, here are some concerns I hope you consider—hospital board, staff and doctors be protected from possible legal action, as was the concern in the Nancy B. story. Consideration needs to be given to situations where the medical staff have concluded that a person would not benefit from aggressive treatment—I think the phrase was futile treatment in an earlier presentation today—but where one or some family members, out of their emotional difficulties in letting go, will not agree to switch to comfort or palliative care, consideration needs to be given to the issue of when is ongoing treatment really an invasion or an assault to the person's body.

I notice on the CBC news this week and in the Winnipeg Free Press today that the federal-provincial Health and Finance ministers are deeply concerned about cutting costs to maintain our universal medicare. On page 5—I am sure some of you have browsed through it already—there is this quote that Canadians will have to be more careful when they spend their health care dollars for everything from hip replacements to Caesarean sections, Health and Finance ministers agreed yesterday. Federal Health Minister Bouchard suggested as many as 30 percent—wow!—30 percent of the medical procedures performed in Canada may be unnecessary.

I would like to see some documentation to that. Certainly there could be considerable financial savings and greater respect for people if that is the case.

My sense is that we must scrutinize not only the ethics but, also, the finances of keeping people existing for months or years in a state which they

would not agree to if they were able to state their wishes.

I think specifically of many people on a ward at Deer Lodge who are extremely brain damaged. I visit there and I commend the caring staff, but I wonder of the wisdom of keeping these people captive to a system that seems to deny that there is dignity and that there is a blessing in death.

I visit in many seniors' residences and notice that friends once active and alert have become fillers of chairs. Their once sparkling eyes have become but vacant stares.

In many such cases, modern medicine and technology have become more of a curse than a blessing. In years past, most of these people would have died naturally with pneumonia or other complications. It seems to me that these difficult questions must be faced. Bill 73 does not address the ongoing ethical and financial issue of what to do with the thousands of others who make no living wills.

Further on the next page, on page 3, I will just highlight a quote from the CBC commentary statement I made the day after Nancy B. died: Because of the media hype focused around Nancy B. and issues—this is the second paragraph—related to euthanasia and the right to a good death, which is what the Greek word means, Nancy B. will long be remembered for her courage to assert her right to self-determination, which is the philosophy behind the Law Reform Commission, the right of self-determination.

Further down in the last three paragraphs: With the increasing demands on limited health care dollars we will have to make more and more tough ethical decisions. Should we spend our money keeping a severely brain damaged person existing while we say we have no money to do heart surgery that could give someone else years of significant living?

As a clergyperson, I have learned a lot about death and dying from those who do it, and Canada has learned a lot from Nancy B. All main world religions teach that death is not to be feared. There is a time to be born and a time to die. Nancy B. and many others like her are choosing their time.

\* (1450)

Nancy B. has offered us not just an example of self-determination but, rather, as well an invitation to come to terms with our own death. Nancy B. has

taught us about the sanctity of life, as well as the sanctity of death and how we can honour a person's spirit in their living as well as their dying.

On pages 4 to 11, and I am only going to make reference to it, this is the reprint from the Canadian Medical Association 1992 Issue. I have written for permission to reprint it and have not received a response yet. I just received this the other day.

I would like to highlight on page 4 some of the research that has been done with Ontario doctors. This might be helpful for your committee's work and for implementation stages. The questionnaire was mailed to over a thousand family doctors. The results indicated that 86 percent of the doctors favoured the use of advance directives, but only 19 percent had ever discussed them with more than 10 patients. Most of the physicians agreed with statements supporting the use of advance directives and disagreed with statements opposing them.

Then down toward the conclusions: Family physicians favour advance directives but use them infrequently. Most physicians support offering them to terminally or chronically ill patients but not all patients at the time of admission to hospital, although about 40 percent say that.

Although governments emphasize legislation—which you are dealing with today—most physicians believe that public and professional education programs would be at least as likely as legislation to encourage them, to encourage the doctors, that is, to offer advance directives to their patients.

On page 5 of that, just a brief statement that connects us with the United States and references to Dr. Belik's comments, the second paragraph down, in the U.S., 49 states have enacted legislation on advance directives. Moreover, the patient's self-determination provisions of the 1990 U.S. Omnibus Budget Reconciliation Act require—get this—requires hospitals receiving Medicare and Medicaid reimbursement to inform all patients at the time of their admission of their right—just their right—to complete an advance directive.

In Canada, Nova Scotia and Québec have legislation supporting proxy directives. No province currently has legislation on instruction directives. Then again they reference, 15 percent of people in the U.S. have completed an advance directive.

Now if that happens after ongoing education here in Manitoba and in Canada, we are only getting to 10 to 15 percent of the people. I am not sure how

we deal with the issues related to these questions with the 85 percent of Canadians in the future years.

I want to refer on page 12 to a document that is a reprint that highlights themes from this booklet called, *Let Me Decide*. Then on page 13 through to 16, you will find a copy, a tear-out that is available, the tear-out from the middle of the booklet. This is a specific one that has been developed by a Dr. Molloy, and a nurse, Virginia Mephram, of the Alzheimer Society in Ontario. Some of you may be familiar with it. It has been updated, and I would hope that you would study it and look at the chart as to how it might be simple enough to help people indicate what their wishes are without being so complicated that they or their doctors or their families are confused by it.

In summary, I commend you for your work. I am proud to be part of a province that may have the first legislation—I do not know how the Ontario schedule is developing—but may have the first legislation of this kind in Canada.

**The Acting Chairperson (Mr. Rose):** Thank you, Mr. Oldham. Are there any questions or comments for the presenter?

**Mr. Cheema:** Mr. Acting Chairperson, first of all, again, we are very grateful that Mr. Oldham has come and made the presentation, because we had received a note from him earlier indicating his views on the whole issue.

I think you have touched on many important issues in terms of the wishes of the patient and your involvement in various hospitals and what you see, how the patients are sometimes unable to make decisions. Sometimes their life is being prolonged without any major outcome and without having dignity of life attached to that. I think this bill, as you have said, will address some of the issues but certainly will not go far enough which you are asking, and I think time will tell how we can change that aspect.

One of your concerns, on page 4 of Bill 73 is that to prescribe form. What you have suggested and, in your brief, you have given us a page from the book you have referenced a number of times. I am sure the minister knows that there is a form in the Law Reform Commission report, and I think that may solve your concern and give some guidelines how the form can be developed and explained to the patient.

The other issue is the public education. That has to be done, that has to be a major component, as Dr. Belik and yourself and other presenters have made very clear. That should be probably the policy of the hospitals as well as the health care providers.

Certainly those are my comments. We again appreciate your willingness to come and participate in, as you have said, a very important document, the first in this country to at least give guidance to other provinces, that we need to have such a law in this country to make sure the dignity of an individual patient and individual citizen is being maintained.

**The Acting Chairperson (Mr. Rose):** Mr. Oldham, do you wish to comment?

**Mr. Oldham:** Not directly, but I appreciate your comments, sir.

**Mr. Chomlak:** Mr. Acting Chairperson, I would also like to thank you for your presentation, Mr. Oldham. There are some interesting suggestions in there that I noted, notably the inclusion perhaps of a wallet directive—I thought that was interesting—also, the statistical information you provided us and, also, the information from the United States about hospitals that provide that kind of information on admission. That strikes me as a very useful tool, because education is clearly one of the most significant factors in the introduction and the passage of this bill.

It will fundamentally change many aspects of our society and will touch everyone in this province, so the means by which the public is educated becomes paramount. I think having health care professionals and other institutions advising people as well as some of those other suggestions, would be useful.

Your example of a sample directive is useful. I think the legislation probably covers that in that the Section 11 is not mandatory. It says, and I think it is done that way—I suppose the government or the drafters would probably point this out as well—the legislation says that the Lieutenant-Governor may by regulation, but not make it mandatory.

I expect, and we will ask this I suppose, and perhaps the minister would be prepared, likely there will be by regulation a kind of directive that will be provided. I suspect there will be, by regulation, a sample directive, so that will be taken care of. I thank you for that suggestion.

**Mr. Oldham:** Sir, yes, that would be very helpful, especially in the educational phase of this program where a sample is provided so people can use it or

modify it. I would not want to have something that is mandatory. For example, in the case of my friend who died at the Grace, it was a two-line verbal statement to me that was honoured. Certainly, we need to have that flexibility. I know that there are people who need some direction on what they want to say, and I would affirm that.

The other thing I want to acknowledge is that while many of you may not read *The Winnipeg Sun*, or consider Peter Warren on your Christmas card list, there is an article in today's issue of *The Winnipeg Sun* specifically about living wills—kind of preparing for today, I take it. He talks about the resources now with computers, whereby you can have a system built in so that regardless of where you live, they can have quick access to your living will if you are in another part of the country, even in another part of the world.

(Mr. Chairperson in the Chair)

Dr. Molloy is developing this computerized network of system where regardless of where you are, access can be quick by a few buttons to your living will that is on file in a central registry. That would resolve one of the issues as well as doctors not knowing if there is one, is there one, where is it, when can we get it, do I treat aggressively for the next five hours until I get one, or whatever. That is also pending in this ongoing discussion with Dr. Molloy in Ontario.

**Mr. Chairperson:** Thank you, Mr. Oldham.

The next presenter is Gordon Mackintosh, the Manitoba Association for Rights and Liberties.

**Mr. Gordon Mackintosh (Manitoba Association for Rights and Liberties):** We provided a brief to the minister and to the opposition critics, the one that is being passed around now. I sat at this table too long to want to go on very long here. I will just be very brief.

First of all, I want to commend the government for this bill. This really is an excellent piece of legislation. It is one of the most progressive and comprehensive of its kind, and my understanding is, that goes for all of North America.

\* (1500)

I was surprised to hear that there are, I heard 47, and the gentleman says 49, states in the U.S. that have similar legislation of varying degrees, so we are joining a big family. Our experience will be important to oversee.

In particular, we will want to see over the next several years, to what extent there is knowledge of and use of this legislation. If there are some deficiencies in that regard, we hope that the government will look to changes, whether it be by the physician taking a more proactive role, or perhaps by other changes.

I also want to commend the Liberal caucus for the introduction of its Bill 16. That was also an excellent piece of legislation.

I also want to commend the NDP caucus for what I understand is its general support of this bill, and certainly for the concept of advance directives.

MARL, as I say, strongly supports the bill, and therefore, the comments that I will make now, are not so important that they should hold up the bill if they cannot be dealt with at committee.

Section 23 of The Wills Act says that if you do substantially comply with the formal requirements for making a will, the will can still be validated. We think that is good provision.

There are, although not a lot, some requirements that have to be met. For instance, if one spouse signed an advance directive, there could be some difficulties under this legislation. In certain circumstances, it may very well be that is an advance directive that should be relied on, that we can feel assured represents the interests or the wishes of the person who is the subject. We think there should be an outlet for someone to go to court to get an advance directive validated even though all of the requirements may not have been met. That is recommendation No. 1.

Recommendation No. 2 is that we think there should be a provision in the bill which allows or recognizes advance directives made in other jurisdictions. I know in speaking to Legislative Counsel earlier, he pointed out that this legislation really has such minimal requirements that we should not be concerned but, if there are 47 or 49 states in the U.S. that do allow for advance directives, you never know what one will come across. We think that an advance directive, no matter where made, should be valid in Manitoba.

Our third recommendation is regarding the consent of proxies. We think that it should not be necessary certainly for a proxy to give prior consent. In speaking with Legislative Counsel, it is the opinion that the bill does not require prior consent, so recommendation No. 3 has been satisfied, I believe.

Recommendation No. 4: Amendments to The Human Tissue Act are needed, we propose, and we understand that that will be addressed.

Recommendation No. 5 is clarification in Section 3 regarding the status of advance directives insofar as The Mental Health Act is concerned. This was addressed in detail by Mr. Dalmyn from the CMHA, and we endorse that. We hope that can be clarified.

Recommendation No. 6 regards the Title of the act. The Health Care Directives Act I think is a bit cryptic. I do not think people know what a health care directive is. Now that is easy to say, but what is the alternative?

People talk about this as living wills, should it be the living wills act, but there is all kinds of baggage that come along with that. Living wills sometimes connote the ability to commit—one saying, you know, kill me, or something like that, so there are lots of other considerations. I do not think “living wills” is accurate. Perhaps the Medical Consent Act, which is the title of the Nova Scotia legislation, may be a bit better. It is a bit too broad, but then I think The Health Care Directives Act is a bit too broad.

I would invite the committee to consider whether the act truly will enable public understanding of this scheme.

Recommendation No. 7: Again, it is important that we have educational programs in place to inform the public of what this bill entails.

The other two recommendations we have set out in writing there, and I will not speak further to them. Those are the comments of our association.

**Mr. Chairperson:** Thank you, Mr. Mackintosh. Are there any comments or questions?

**Mr. Cheema:** Mr. Chairperson, I have developed a good habit of appreciating individuals who have come forward in making presentation and, Mr. Mackintosh, your association has done a good job. We have all worked very closely on a very nonpartisan basis to develop some regulations which are going to help all individuals in Manitoba, and this is one very good example.

We appreciate your concerns and, certainly, some of them have already been addressed. As far as some of the others are concerned, we have the time of the committee and we can probably ask the minister and the legal counsel for some explanation.

I just wanted to express our appreciation for your ongoing support for the right of a patient and the dignity of individuals, which this bill is simply asking

for—give what is best for the patient. They should be the best judge, not any one of us.

**Ms. Wasylycia-Lels:** Mr. Chairperson, I would like to thank Gordon Mackintosh and all members of the Manitoba Association for Rights and Liberties, not only for the presentation this afternoon which is very excellent and detailed, but also for their years of work on trying to move Manitoba in this direction of recognition for rights of health care consumers and that of course, nowhere is that more necessary and apparent, than an area like directives and living wills.

I have a couple of questions. The first has to do with your No. 1 recommendation on substantial compliance. Can you tell me, I do not know The Wills Act, do you know the wording under The Wills Act and is it directly applicable for the situation? What would you recommend specifically in terms of amending Bill 73?

**Mr. Mackintosh:** The statutes may be at the back. I do not recall the exact wording of that. I do not have that with me. My understanding is it says that where there has been substantial compliance with the requirements for making a will, the will can be validated, and I believe it is on court application. Well, it would be on court application, certainly.

**Ms. Wasylycia-Lels:** How strongly do you feel about that amendment? Is it something that we should push for hard at this committee meeting, or if there is no will on the part of the government to incorporate such an amendment, do you feel it can be dealt with in any other way?

**Mr. Mackintosh:** I certainly would not recommend that anyone go to the wall on that one. I think, though, if there is some general support for that, it should be included. It just ensures that the advance directive is available in all possible circumstances so long as it likely reflects the will of the patient.

Let us face it, this bill has very few formal requirements, but there are some, and there may be circumstances where even those particular requirements really do not prove anything.

**Ms. Wasylycia-Lels:** Let me then ask your recommendation with respect to some of the suggestions made in earlier presentations about actually making even more specific requirements around the directive.

For example, the MMA brief recommends specifically that the directives be dated and be signed. They also call for a witness and a number

of other things. I am wondering what the recommendation of MARL would be with respect to looking at some of those considerations.

**Mr. Mackintosh:** We would strongly oppose those kinds of requirements. That is going the opposite way of where we should be going.

\* (1510)

The common law, the Ontario Court of Appeal has said that the Jehovah's Witnesses card which is simply preprinted and signed only, no date, no witness, just a signature, is good enough. It is critical that the Manitoba legislation not kick out the Jehovah's Witnesses card, because if it is good enough for the rest of Canada, it should be good enough for Manitoba.

**Ms. Wasylycia-Lels:** Okay, I appreciate that response from you, Mr. Mackintosh. Could you help me out, though, with respect to directives that may be very clear and ambiguous. This also has been raised by the MMA and I believe others.

I am raising this issue now, not from the perspective of worrying so much about liable suits for doctors, as I am about making sure we know the intentions of the consumer and the intentions of that directive. Should there be anything in this law, anywhere, that does somehow not penalize a doctor or a physician or a health care professional from making a decision out of good faith, interpretation of a directive, when that directive is ambiguous and unclear?

**Mr. Mackintosh:** We are of the opinion that the act as drafted is good enough. I do not think we can make lay people lawyers or make them go to lawyers. I think any words have to be reasonably interpreted. There are always questions of interpretation in any document, in any written word, so there will be some judgment calls that will be required. The test will be, was it a reasonable interpretation, and if there is goodwill exhibited by the health care professional there should be no liability. I mean that is just common sense. I do not think we need any tightening up of the legislation in that regard.

**Ms. Wasylycia-Lels:** I would like to raise one other matter pertaining to an issue that has been raised previously and that has to do with Section 21, the question about no onus to inquire about a directive.

I am wondering where MARL stands on this issue of whether or not to have something in legislation that may encourage or discourage depending on

which wording you choose, reasonable inquiry or whether it is best to leave it out of the act and leave it fall under common law cases to date.

**Mr. Mackintosh:** After listening to Mr. Dalmyn, I thought yes, that is a good point, and although the subcommittee of MARL that studied this has not considered that, I would think that MARL and the health care consumer committee would support the repeal or the deletion of Section 21. I would think that it may be reasonable in some circumstances for a physician to make inquiries.

**Mr. Cheema:** Mr. Chairperson I just want to ask, I first thought I would end my remarks but I want to know about this Section 21. You are asking that we should delete the whole section and leave it very vague, and then how is the law going to interpret that section. That means that if as a patient you are wasting your one physician or you are wasting one hospital or something goes wrong, you are putting that health care provider at a very unwanted risk. I think it is very open. It simply will, in my opinion, I am subject to change, but I want to know how do you recommend that we should take this out completely.

**Mr. Mackintosh:** There are three options here, either leave it as is, take it out, or three, require the professional to make reasonable inquiries. Now either one of those, I think, would be fine. I would say that even taking out Section 21, I still would think that the court would conclude that there should be reasonable inquiries made.

For instance, if a statement had been given to a health care provider that a health care directive existed or that oh yes, I wrote this down or Joe Blow will take care of that. If there is something that twigged in the health care providers mind here, or should have twigged, that there is a health care directive, then I think an inquiry should be made and I think the law would require that. I think that without Section 21 that would be good law.

**Mr. Cheema:** Mr. Chairperson, can Mr. Mackintosh tell us then, if we have to include that, that means that we may have to amend The Manitoba Medical Act and the College of Physicians regulations also to make sure the physician follows those guidelines. If we are forcing a health care provider, not only physicians, and the hospital, personal care homes and other health care providers who are involved in a patients care basically, then we have to change so many other regulations to make sure they are following the law.



Do you think that is one way of—it is not opening the whole area of problems and trying to do something which may or may not be possible?

**Mr. Mackintosh:** I do not come from a considered study of this issue, and so I would defer to your knowledge of regulations under The Medical Act in that regard. I would think that just as a matter of good ethical practice, one would ask, is there a healthcare directive, just as much as one would ask, do you have any allergies?

**Mr. Cheema:** Mr. Chairperson, that is why I think if we are to follow your guidelines and your views and then the definition under the ethical physician, I think we need to probably look in terms of a College of Physicians regulation and also The Manitoba Medical Act, because if we are going to ask them to follow all the instructions, then there has to be a law which will force them to do it. We cannot just rely upon something which we would like them to do, but that is part of just one aspect of the law and not the others.

I am just concerned, and certainly we will ask the legal opinion from the minister's office whether that is possible or not and what are the long-term implications of putting such a regulation in this law.

\* \* \*

**Mr. Chairperson:** If there are no further questions or responses, then we will proceed to Bill 75, and I am going to ask Mr. Mackintosh to stay up front and continue on with his presentation in regard to The Health Services Insurance Amendment and Consequential Amendments Act. Would you care to make your presentation now?

**Mr. Gordon Mackintosh (Manitoba Association for Rights and Liberties):** I have just one concern, Mr. Chair.

**Ms. Wasylcia-Lels:** Could I suggest just a quick five-minute recess while we inform the Minister of Health (Mr. Orchard) that his bill is now up. I think he would want to be here.

**Mr. Chairperson:** What are the wishes of the committee? We will recess for five minutes.

\* \* \*

The committee took recess at 3:17 p.m.

#### After Recess

The committee resumed at 3:41 p.m.

### Bill 75—The Health Services Insurance Amendment and Consequential Amendments Act

**Mr. Chairperson:** Would the committee come to order, please. I am going to ask Mr. Gordon Mackintosh of the Manitoba Association for Rights and Liberties to come forward, please, on Bill 75, The Health Services Insurance Amendment and Consequential Amendments Act.

**Mr. Gordon Mackintosh (Manitoba Association for Rights and Liberties):** By transferring powers from the Manitoba Health Services Commission to the minister under Bill 75, we ask, as consumers of health care and as the people for whom the health system is for, what assurances are there to ensure our due share of input into health care policy and priorities?

We cannot say that the Manitoba Health Services Commission adequately defended or stood up for the considered interest of consumers. We do not oppose this bill in principle, but raw ministerial power is of grave concern given our experience over the last year or, indeed, the last three years. I hope the Minister of Health (Mr. Orchard) will read these comments.

The Health Care Consumers Rights Committee is comprised of representatives from many organizations, as well as comprised of individual perspectives. It has been active since 1980, conducting seminars, research, advocacy services, and has lobbied legislators and conducted outreach on issues of public concern.

Our experience with this particular Minister of Health has been an acid test. Despite seven requests since last June for a meeting with the minister to discuss what should be our mutual concerns, we have been propelled here today to express our surprise, our indignation, about an administration which has shut out one of the most valuable perspectives that can be brought to this health care system, that of consumers, organized consumers.

Now it can be said that everyone is a health care consumer, but many individuals, despite their individual contribution, cannot bring a perspective in a co-ordinated way with careful research and the articulation of common concerns that our committee can bring.

The minister has created the Health Advisory Network, and its committees do accommodate the

perspectives of many individuals, but the Minister of Health needs more than that. The minister needs to hear from organized consumers. He needs to hear of the common concerns, the research, and the positions that are taken after considered discussion among consumers. The minister should invite our contribution with a welcoming handshake. We need him, he needs us, we are a balanced public policy. We acknowledge that we are but one interest of many, but our organization of consumers, which bridges common concerns, is a valuable resource for this government.

Now I quote the action plan which the Minister of Health has recently unveiled, quote: We are confident that a systematic effort to empower individuals can help ensure that they become an increasingly powerful force for improvement in health services and in the health of Manitobans.

After five months with no reply from the minister to our request, no reply whatsoever from his office or from any official to a request for a meeting, we wrote finally to the opposition caucuses for a meeting with them. There were the welcoming handshakes. Those caucuses eagerly embraced so many of our recommendations that four and arguably five private members' bills were introduced or announced this session to which the government has not even spoken to, to our knowledge, and now this bill.

The minister supplants the Manitoba Health Services Commission. The Manitoba Health Board is created. Manitoba's health care system, to my understanding, is the largest single item of public expense in this province, and it is arguably the most critical in terms of human life itself and community wellness. Yet, the evidence is that this area is the least accountable to the community, let alone to its consumers.

Nowhere in Bill 75 can assurances be found that greater public input or patient empowerment respecting health care policy or priorities will be facilitated. There is no plan for, for example, publicly elected hospital boards or publicly elected regional health boards. In the least, the Manitoba Health Board should be given specific advisory responsibilities. Its composition should be clarified to require the appointment of consumer representation. Recall the words of the action plan.

Even with these recommended improvements, the minister still must adopt an attitude of openness, for he represents the interests of all stakeholders in

the health care system. We urge and we request the minister to share his valuable time with our committee to explore a perspective that will ensure input from which the government must make its decisions from an enriched perspective. Thank you, Mr. Chairperson.

**Ms. Judy Wasylycia-Lels (St. Johns):** Mr. Chairperson, again I would like to thank Gordon Mackintosh and all members of the Manitoba Association for Rights and Liberties, for appearing before us this afternoon making a brief that is very much relevant not only to Bill 75 before us today but also in terms of the government's stated health care reform plans.

I again want to commend the work of the association for year after year, over the last decade or so, pursuing advancement on behalf of health care consumers, seeking meaningful input in a role in the decision making around health care and working with individuals and communities to help themselves. I think that the goals and objectives and record of MARL, and particularly your health consumers committee, are examples for all of us and particularly for the government of the day.

Mr. Mackintosh, you have referenced your own experience in making contact with this Minister of Health (Mr. Orchard) and this government. It is not unlike examples told to me from other organizations and groups. It is not unlike the experience some of us as MLAs have experienced in getting some sort of reasonable consideration to our inquiries, questions and requests for information.

I, in terms of my own example, can cite numerous examples where we have written to the minister and after over a year receiving no responses. It is clear that the minister, when he wants to respond on an issue, chooses to do so and, when he does not want to, probably for philosophical or policy reasons, does not do that.

#### Point of Order

**Hon. James McCrae (Minister of Justice and Attorney General):** My point of order, Mr. Chairperson, is more in the nature of a question. Does the honourable member have a question of clarification to put to the presenter, or does she want to make a speech? There is a time to make speeches, but it is not now.

**Mr. Chairperson:** The honourable minister has no point of order.

\* \* \*

\* (1550)

**Ms. Wasylycia-Lels:** Yes, I have many questions to put to the presenter. I am very concerned about the inclusion of the concerns and interests and ideas of health care consumers in every aspect of our health care system, and I think the presenter has given us some very clear-cut examples and evidence of health care consumers being totally, appallingly neglected by the present administration, in particular the Minister of Health (Mr. Orchard).

I wish the Minister of Health were here right now to hear these concerns, because that is the person who is in question, that is the department that we are dealing with, and that is where change has to come from. I hope that he will return soon and hear the concerns of people at this committee.

I have many questions, and I begin with questions around communication between this organization and the Minister of Health. Mr. Mackintosh, you have indicated that you have had seven requests in to the minister for meetings, for responses to information, for calls, and you have not even had the courtesy, I believe, of an acknowledgement. Is that correct? How many different types of requests have you put before the minister in terms of issues when you have sought input, when you have sought information, and have you ever received any kind of response from the Minister of Health?

**Mr. Mackintosh:** Our requests for a meeting began last June, as I said. That was followed up with letters to his office, letters personally to him. It was not until February of this year that we did get a response from the minister. It was a brief response, and the minister at that time said that he is unable to meet with us because of the pressures of the Legislature.

Well, we came down here today to the Legislature. He is not here, so again, he does not hear our concerns. He did arrange for a meeting with two officials of the Department of Health. We met with them and they expressed concern, as did we, that we are discussing policy, and they felt ill at ease discussing policy and suggested, really, your meeting should be with the Minister of Health (Mr. Orchard). Of course, we had to advise them that that was not possible.

These are well-meaning people in our committee. It is a well-established committee, people from the aboriginal community, from seniors, from an

organization concerned about immunization; it is comprised of representatives from CMHA, from the Manitoba League of the Physically Handicapped, from the AIDS Shelter Coalition.

**Ms. Wasylycia-Lels:** Mr. Chairperson, the bill before us, Bill 75, is the amalgamation of the Manitoba Health Services Commission and the Department of Health. By the minister's own words, this is being done in the interest of health care reform, to enhance the opportunity for making inroads in terms of an overhauled health care system that is more effective, efficient and sensitive to the needs of patients and consumers.

I would like to ask the presenter, Mr. Mackintosh, how he views the whole area of empowerment and community self-help models and rights for patients in terms of the health care reform agenda. Can you have health care reform without major changes on the front of empowerment and community self-help models?

**Mr. Mackintosh:** I will just be brief in my response. Our committee is concerned about the lack of consumer input into public policy making. There has been a disproportionate input from health care professionals and administrators in the past. We are not saying there is any ill will there at all, that is just the historical development, that is what is the status quo. There has to be more consumer input in health care, as in many other areas.

Number two, health care consumers have to be more involved in their own personal health. I know the medical profession would welcome that.

On those two fronts, there has to be change. It has been difficult to organize health care consumers. People are in and out of the health care system, they want to leave that experience behind. It is usually not a good experience. It is a time of bad health, a time of high stress.

There are people in the health care system that are long-term users, and they have banded together to form a consumer movement. This is all part of a worldwide movement; there is nothing unique in Manitoba about the health care consumer movement.

There have to be dramatic changes. Certainly Bill 75 does not echo at all the words of the action plan. There is nothing in there that we see that will facilitate patient empowerment, either respecting health care priorities in general or individual health.

**Mr. Chairperson:** I want to at this time remind all members that I believe that there was an agreement to adjourn the House probably at four o'clock or thereabouts. I wonder what the wishes of the committee are, whether we want to continue beyond four o'clock. What is the wish of the committee?

**Ms. Wasylycia-Lels:** Well, I would say if the Minister of Health (Mr. Orchard) is not available to be here, then we might as well adjourn to a time when it is convenient to him, with all of our apologies to the presenters who have obviously taken time from busy schedules to be here to communicate something very meaningful to the Minister of Health.

**Mr. Chairperson:** The bells have started ringing. There will be a vote and we have to recess until at least the vote has taken place. You will have to excuse us, we are going to be required back in the House for the next short while. Thank you.

\* (1600)

\* \* \*

The committee took recess at 4 p.m.

#### After Recess

The committee resumed at 4:12 p.m.

**Mr. Chairperson:** Would the committee please come to order.

**Ms. Wasylycia-Lels:** Mr. Chairperson, just on a point of procedure, it had been generally agreed that this committee would sit as long as the House was sitting. Since the House has recessed, I think it would be important though for us to hear the presenters in committee. It would be my recommendation, if there is agreement, that we hear all the presenters and then move to clause by clause on Monday.

**Mr. Chairperson:** Is that the will of the committee? I had indicated to the presenters that if it was the will of the committee, we would hear all of the presenters and then we can make further decisions from there.

**Hon. Donald Orchard (Minister of Health):** Mr. Chairperson, I would certainly want to hear all the presenters and then we can decide as to whether there is sufficient will and time to complete clause by clause on the bills thereafter.

**Ms. Wasylycia-Lels:** Mr. Chairperson, I think it would be important for the presenter, Mr. Mackintosh, to repeat some of his concerns that he had outlined in his brief so that the Minister of Health can get the full benefit of this presentation. I will ask

some questions that will aid in that process so that we can certainly have a full and complete dialogue on this matter.

(Mr. Bob Rose, Acting Chairperson, in the Chair)

The presenter has clearly referenced the lack of opportunity for the views of health care consumers, patients and individuals who are fighting over a long period of time to get more of an active role for citizen participation in our health care system.

I would like again to ask the presenter if he has seen, felt that any of the recommendations of the Manitoba Association for Rights and Liberties, when it comes to health care consumers and greater involvement in decision making, have ever been considered by this government and, if so, in what areas?

**Mr. Mackintosh:** Mr. Acting Chairperson, we do not have any knowledge of the government considering any positions advanced by MARL, although there was one meeting with Dr. John Guilfoyle and Jean Bigford, who are not, as I said earlier, at the policy level. We have had no response from the minister whatsoever.

As a result of the minister's refusal to meet with our committee, I think the message is clear from his office that the concerns of health care consumers when organized are illegitimate. The actions are not in accord with the action plan. This has been a major affront to the people for whom the health care system is there for.

**Ms. Wasylycia-Lels:** I would like to ask about response from this government with respect to your very extensive brief that you presented to all political parties in the Legislature. I believe it was about six months ago at least. The presenter can clarify that when I ask the question.

That brief provided us with some very useful information and some directions for us as legislators and members of the Assembly to look seriously at something that is happening in many parts of this country. That is the question of greater access for consumers in terms of their own health care records; that was recommendations pertaining to advocacy and some form of program through provincial government to ensure that advocates and some sort of advocacy office was in place to help consumers and health care patients help themselves.

You have long been fighting, and included in that brief, references to some sort of entrenchment in legislation around the adverse effects of

immunization and there were other recommendations. It was, in my mind, a very useful document and we, all of us, took it away and began to find ways to move on parts of it in terms of, we know we have dealt with earlier Bill 73, where the member for The Maples (Mr. Cheema), advanced through Bill 16, the question of health directives. Our own caucus has been pushing for, as well as the Liberal caucus, on the question of health care records and legislation around adverse reactions to immunization.

I have two questions flowing out of that. One is, has there been any response from this government about any of your recommendations in that paper, any sign outside of Bill 73, which of course we all recognize as a positive step, any sign that these ideas are under study, they are being considered, that they are included in one of the numerous reviews, working groups, councils and task forces that the minister has set up around health care reform? Can you point to anything concrete that this government is doing, and do you have any confidence that the minister is looking at any of these issues?

The second part of my question was, relating to the two bills we introduced, Bills 36 and 56, I just wanted you to know that we have tried very hard to promote these ideas through private members' legislation. I said quite clearly, if the government did not want to support our bills and felt it important only for the government itself to bring in such legislation that we would be quite happy if they stole the ideas and ran with the legislation on their own.

We have not seen that, we have not seen support for the private members' bills. Indeed, as you mentioned in your own brief, we have not even had the courtesy of a response on record from this government in terms of those two bills.

I am wondering as a second part of my question how urgently the situation must be considered in light now of the Supreme Court decision of only last week which ruled that doctors must give patients full access to their files.

\* (1620)

**Mr. Mackintosh:** Well, I will answer the first question. There is no concrete evidence whatsoever the government has considered any of our recommendations. Perhaps it might be too much, though, for any organization to expect the government to act on anything that is being

proposed. We do expect, however, the government to listen, at least.

In fact, we never even got to the point of a handshake. We never got to the point where the minister was even in the room and closed his ears to us and just looked at us, but that kind of a response is something that, quite frankly, our committee just never expected. We began the process by a simple telephone call to the minister's office thinking that he would be welcoming our input. I think it is a fresh input. It is one that is very needed and long overdue, so it has been quite a shock.

The Health Care Consumers Rights Committee will continue. It will go on and on and it is growing and growing. I can attest to that just even in the last couple of years. It is a movement. It is going to be around for a long time. If ministers of the day are not listening, it will get more and more difficult for them to close their ears to it.

**Ms. Wasylycia-Lels:** The legislation before us, Bill 75, in my view provides an opportunity for government to begin to address some of the concerns of health care consumers. This reorganization of the department is purportedly to enhance health care reform, as I said earlier. It also transforms the Health Services Commission into a health policy board.

I would like to know if you have had a chance, Mr. Mackintosh, to look at the legislation, determine how significant references are to a health board in this legislation and whether or not that vehicle has been fully developed to allow for the kinds of suggestions you have made, input from consumers, consultation between organizations like your own and government, a body for vetting and pursuing important issues on the health care reform scene. Have you got any comments on the provisions around the Health Board in Bill 75?

**Mr. Mackintosh:** The Manitoba Health Board appears to be given specifically regulatory responsibilities and not policy or advisory responsibilities. If we are going to move toward more public input, consumer input, there should be specified responsibilities regarding policy.

In that regard, the Manitoba Health Board could provide a very valuable service to the minister in an advisory capacity so long as there was a composition set out in the bill requiring that the board be comprised of the several interests in the health care system or in the community.

I do not think that just looking within the confines of the bill that the idea of a Manitoba Health Board should be enough. I think we have to move away from executive domination of health policy.

It is my understanding that the Brandon Hospital budget is larger than the City of Brandon budget. I do not know if that is accurate or not, but that information was relayed to me once. The Attorney General (Mr. McCrae) may know better. That is indicative, when you look at the politics surrounding Brandon City Hall. They are publicly elected, they are accountable, a lot of issues in the press. One looks at the hospital, and it is virtually a self-appointed board. What control does the public have over health care spending?

Look at education. What a vast distinction. When we look at health care, you have to look too at who are the gatekeepers. It is well-known that it is the doctors who control so much of the spending in our health care system. We have to move away from that. We have to have greater input. We need that. We have to have control.

The minister, I am sure, has that frustration every day. How do I get control of these costs? How do I get on top of a rationalized policy? We can accommodate that by having more input.

The consumer perspective is so critical. Unless the providers know from the consumers how their services are being received, how can we move toward a truly effective system?

**Ms. Wasylycia-Lels:** Would you conclude that in fact greater consumer participation in decision making around health care, a greater role in terms of their own health care decision making themselves, greater inclusion on the boards of hospitals and health care clinics and other facilities all would add up to in the long run cost savings for government and a more effective, efficient health care system?

**Mr. Mackintosh:** Absolutely. Our proposal alone for a patient advocacy office would help to rationalize the system. There would be an initial cost, but think about the savings down the road: reduced risk of malpractice; dealing with complaints; most important, providing better care, care that is more responsive to individuals; reducing stress on those who are in too much stress already. That is one example there of where consumer input, consumer expression of concern can lead to a better system.

The health care system has been long and evolving, while medicare much shorter, but we still have this mentality that the consumer must be a passive recipient rather than an active participant in health care. That is changing so quickly. If we tap the growing consumer self-awareness, we will really have a good health care system that will be around forever, but to maintain the paternalism of the old system is not the way to go. The action plan acknowledged that.

**Ms. Wasylycia-Lels:** Just a final comment and question—again I appreciate your taking the time to be here, Mr. Mackintosh, and we appreciate your patience in trying to get some action in response to all your many initiatives over the years.

I can imagine how disappointed and discouraged some members of your association may be as a result of this absolute void in terms of government response, the total lack of communication as a result of the minister or his office refusing to return phone calls, return letters, agree to meetings, at least consider the ideas. We can certainly understand disagreement on ideas, and there are philosophical approaches and different political positions in all of these issues, but what is so hard to understand is an absolute refusal and resistance and intransigence on the part of the minister to even sit down with you and talk about those concerns and those ideas.

I think that all of this is doing a disservice to Manitobans generally and to our health care system as a whole. I think there is no shortage of evidence to demonstrate that health care reform can never truly be accomplished without a much greater role by citizens in their own health care, by a much more democratic, participatory approach to this whole area and entrenched respect for the rights of individuals as they pursue good health care for themselves and indeed for their whole community.

So again I thank you and I express regrets that you have not been able to make any inroads in terms of reaching the minister. I hope that by being here today and all of us expressing our concerns that you will meet with some success in the near future and that the minister will actually make a commitment today that he will sit down and meet with the consumer rights committee of the Manitoba Association for Rights and Liberties. I do not think that is too much to ask. I do not think that should be laughed at or smirked at. It is a reasonable suggestion. I would ask the member if he would

expect at least that much in terms of today's proceedings. I assume that despite what has happened, you and your committee are still quite willing to meet with the minister as soon as possible.

**Mr. Mackintosh:** The committee has never been at odds with the minister. We have never had a meeting. We have never discussed items of mutual concern. The committee warmly requests that the minister meet.

**Mr. Gulzar Cheema (The Maples):** Mr. Acting Chairperson, I appreciate Mr. Mackintosh's presentation and their efforts to educate not only the people at large but also the caucuses. We have benefitted personally from their approach, and we have in fact tried to bring a few private members' bills, and there seems to be some duplication. The intent was to do what is best for the people of Manitoba, and I think that has been achieved to some extent.

\* (1630)

I have a question in terms of Bill 75. Mr. Mackintosh has said that it is going to give too much power to the minister. I do not know whether Mr. Mackintosh is aware of this or not, actually this kind of policy has been discussed in the past. It was between 1981 and 1987 and then after '88, and I am subject to correction, it was the party position of all three parties that they will try to combine this board and Manitoba Health Services Commission under one roof and try to promote the quality of health.

I just want to know, what are the specific areas of concern in this bill that you would recommend that we could make some changes to? Certainly it is not a perfect document, and I do not think any government bill is always perfect but, certainly, we can have improvements.

I have in front of me a letter by the Manitoba Medical Association simply outlining what I have said. There are certain areas in this bill which are very important. As you know, there has been a public debate about the use of health care resources in terms of the medical practitioners. Some of them have come under a lot of scrutiny by the media, that the Department of Health was not able to release the names of some of the professionals who were, in the eyes of some, not doing a good job in terms of their billing practices were not right. I think this bill is going to address that part.

It is very important that people have the right to know who is not doing right within the normal

patterns of practice. I think this bill is going to address that part, and that has been supported by many.

I do not want to take too much time. I just want to know from you which part of this bill you think is not going to be serving the public interest. I will give you an example. Whenever we ask a question in the House, and it has always been the minister sitting in front of me, in terms of asking a question, he will say, it is the hospital's responsibility. Hospitals are making budget decisions. The hospitals are responsible to make their own decisions in the long run, but this kind of combining two departments under one department and giving the minister responsibility, I think it will make the minister more accountable.

In my view, I think the minister and this government are taking a political risk. They have to answer. They have to provide the budget line. They have to tell how much money is going to be given to individual hospitals, how the money is going to be spent.

I just want to know from you, do you agree with that kind of approach, because that is what the electorate wants. They want us to be more responsible, and I think that part will address that issue at least. That has been the party position of all three parties. I would like to know when we are discussing clause by clause how the three parties are going to vote on this. If there is any major shift, then that will be very interesting to know.

**Mr. Mackintosh:** If I did not make it clear in my initial comments, I will do so now. We do not oppose, in principle, this bill. We think that it is important that the minister be clearly accountable and not hide behind Health Services Commission when it comes to decision making.

Having said that, we do not oppose what is in this bill so much as what is not in this bill. What is not in this bill is an advisory role for Manitoba Health Board, No. 1; No. 2, any scheme to facilitate more public involvement in the health care system, whether it be through elected hospital boards, or regional health boards. The action plan was just released, here is the bill, this is the pudding, what is in it? There is nothing here to encourage, to facilitate patient empowerment, consumer input, public role. That is the extent of my comments.

**Mr. Cheema:** Mr. Mackintosh, I think that helps to clarify because, while I was coming and going out of the committee room, I thought that the whole

approach was to oppose the bill, but that will help. We will ask the minister at the committee stage to address those issues.

Certainly, I want to assure you that our caucus will do everything possible to make sure the consumer, and that includes all of us, get the best quality health care. If that means to give more accountability, which it should, to the minister of the day, I think that is the way to do it. No bill is perfect and we can always improve on these things.

**The Acting Chairperson (Mr. Rose):** Are there any further questions or comments to the presenter? If not, I thank you, Mr. Mackintosh, for your presentation.

Ms. Mary James, private citizen.

**Ms. Mary James (Private Citizen):** Honourable members of the Legislature, committee members, and ladies and gentlemen, I welcome the opportunity to speak before the standing committee today concerning Bill 75.

It is a fundamental and vital principle of our democratic system of government that individuals have the opportunity to express their concerns, ideas and thoughts with their elected representatives. As the late Martin Luther King once said, when an individual is no longer a true participant, when he no longer feels a sense of responsibility to his society, the content of democracy is emptied.

I think the essence of the matter and what I would like to stress concerning Bill 75 is the necessity of consumer groups being included on the Manitoba Health Board. I feel that I can confidently say that we, the consumers of our health care system, are the experts. We are the users of the system and, in many cases, we have experienced the flaws in the system. We can offer valuable advice to the Minister of Health (Mr. Orchard) on cost-saving measures and improvements to health care. Thus it is essential that consumers be included in the decision-making process.

At this point, I must express my dismay and frustration that, as a member of the Health Care Consumers Rights Committee of the Manitoba Association for Rights and Liberties, we have been unable to obtain a meeting with the Health minister. I am new to politics. This is my first time in a situation like this, and I must confess that I was very dismayed at the lack of an opportunity to meet with the Honourable Mr. Orchard. I am an optimist

though. I do not like to dwell on the past, and I look forward and trust that in the future the health care committee of MARL will be able to meet with the minister. Thank you.

**The Acting Chairperson (Mr. Rose):** Thank you, Ms. James. Are there any questions or comments?

**Ms. Wasylycia-Leis:** I would like to thank the presenter for taking time to be here all afternoon to wait for a turn to present on Bill 75.

I would like to ask Ms. James: Since she has been in the field in our community fighting very hard for some way to deal with adverse reactions to immunization which can lead to disability of children or death of children, and I know Ms. James can speak to that very personally, I would like to know, after all this time of fighting for some legislative mechanism to deal with mandatory reporting of adverse reactions and to require doctors to provide information to families before immunization, what kind of response she has received at any point from government. Has there been any response either in terms of proposed legislation that MARL has brought forward or any indication that there are other ways that they are dealing with this issue?

\* (1640)

**Ms. James:** From the present Conservative government, we, as I mentioned, have been unable to meet with the minister, although we have tried for the last year, actively attempted to get a meeting. The Liberals and the NDP met with us and certainly were very supportive of changes. I appreciate the fact that Ms. Wasylycia-Leis introduced a private members' bill on March 9, Bill 56. Essentially it is a safety bill for immunization, to help prevent adverse reactions and deaths.

This can be done very simply by taking a detailed family medical history to rule out who the high-risk children are that should be eliminated from the program and warning health care consumers, parents, caregivers of the risks and adverse reactions to the vaccines. Presently, most parents are not aware of the serious side effects. Finally, and most importantly, is a mandatory reporting system of adverse vaccine reaction so we know the true number of children who have either died or been brain damaged from the toxic effects of the vaccines.

**Ms. Wasylycia-Leis:** Mr. Acting Chairperson, just to let Ms. James know, I am no further ahead in terms of understanding government response to



this proposal in terms of some legislative mechanism to deal with adverse reactions around immunization. The minister has not put any comments on record, and there has been no indication to me if the bill is flawed or if there are problems with it or if there are other ways of achieving the same objectives. Unfortunately, I remain very much in the dark around this whole matter. I fear that we will not be able to achieve any movement on this legislation this session although, like you, I am an optimist and will keep pushing onward and forward in terms of these kinds of suggestions.

I will say and put on the record again for the benefit of the Minister of Health (Mr. Orchard) that if he has other suggestions for dealing with this area, which requires some attention and action, then I wish he would say so and I wish he would come forward with either a new bill or amendments to my bill or another mechanism for dealing with your very important concern.

I have a final question that has to do with you as both an individual citizen and a member of a group that has worked long and hard over the years for better rights for patients and more involvement by consumers in decision making on health care. What does it do in terms of trying to keep people involved and to encourage people to get involved and to start making them become more active, when they know that every time they speak up they are hit with either a brick wall or just nothing? How do you keep people interested and motivated and not becoming cynical when that kind of situation happens?

**Ms. James:** As I said before, it is very discouraging and, actually, I was quite appalled that it would be so difficult to meet with the Health minister. I feel I have legitimate concerns. My daughter died as a result of a vaccination program that is promoted and mandated in this province. I am in touch with four other families in Winnipeg whose children have died as a result of the DPT polio vaccines. We feel very frustrated that we are not listened to and it is very difficult to get a meeting.

All we want is safety. We want to prevent baby deaths and brain damage. That is the bottom line. It is really very discouraging when we know we have something positive to offer and we just cannot get the ear of the minister. I am hopeful that we will receive a commitment from the minister in the near future to meet with him.

**Mr. Cheema:** Mr. Acting Chairperson, we have also met with Ms. James on many occasions. Your main concern is today the public participation in terms of to contribute toward the quality of health care in Manitoba. I take your concern very seriously, because you are not trying to take away something from somebody, you are trying to give your knowledge and your time and your efforts. I would ask the minister, I request him, that there are individuals like you, if they want to participate and give some ideas, it should be taken seriously.

That will help the minister definitely, no question about that. There must be some reason. I do not want to speculate on those, but my way of thinking is to try as much as possible. Without taking much time, I want to say that we will certainly request the minister today that efforts should be made and make sure of that especially when we see the health care reform.

Health care reform is not going to deal with only a year or two years, it is going to deal with the years to come.

Many things are happening, and we have said it as a party caucus that positive things are happening. To make sure those things happen you have to help us in terms of implementing those things. If I have my choice, I will get you involved so that we could be successful.

I am simply asking the minister to consider that and take a positive suggestion from an individual like you who has everything to give. Thank you.

**The Acting Chairperson (Mr. Rose):** Are there any further questions or comments for the presenter? If not, I would like to thank Ms. James for her presentation.

**Ms. James:** Thank you.

**The Acting Chairperson (Mr. Rose):** Ms. Elizabeth Wood, private citizen.

**Ms. Elizabeth Wood (Private Citizen):** First of all, I will have to ask you to forgive me if I seem to ramble on or if I forget myself in the middle of a sentence.

I have Lyme disease. I contracted it in Manitoba in 1985 and I have been ill since then. I only heard of Lyme disease in 1989, one day after my daughter's birth. Unfortunately, even with my being in contact with the top doctors, getting the best information, it has been very difficult to convince the Manitoba doctors that we have the disease here.

I have been in contact with the minister's office on many occasions hoping to get my daughter early

treatment, which is very important in Lyme disease, because it can be eradicated if it is caught in an early stage. We have just come back from New Jersey to see two specialists there. We have both been diagnosed with chronic Lyme disease, which is very debilitating. I have many neurological symptoms which we hope at some point I will be able to get rid of. My daughter has had pneumonia eight times since last July. They have not been able to take her off the antibiotics, because her treatment was too little, too late.

Now I am wondering about this Bill 75 because, being in contact with the minister's office, it has been three years, and I was told since January we would be sent somewhere—I was hoping.

I finally in March made an appointment on my own because I just felt we could not wait any more. I waited right up until the Friday before we had to leave that next Sunday, and I got a letter about three o'clock in the afternoon from the MHSC saying that the only way we would be sent to these doctors was if we were willing to sign a paper saying that we would never request to go somewhere again. Unfortunately I could not do that, because doctors do not believe in Lyme disease in Manitoba.

\* (1650)

So I went on my own and, like I said, we did come back with a diagnosis. Now we have a struggle ahead of us wondering if we will get treatment here, wondering if we are going to have to go further and go back to New Jersey to get proper hospitalization and proper treatment for my daughter, because right now she does not have a future. I have been told she can either become retarded if she does not get proper treatment or possibly even die.

It is a very dangerous disease, and I am hoping that this bill will actually help us as consumers possibly have more of an input.

I do hope that they put a special clause of some kind in there to make it possible for us to be able to go to some place where we can be heard quicker than what I was heard.

I want to bring to everybody's attention here, there is Lyme disease in Manitoba. I certainly hope that this present situation will improve. Thank you.

**The Acting Chairperson (Mr. Rose):** Thank you very much, Ms. Wood. Are there any questions or comments before I recognize Ms. Wasylycia-Leis? If you would be more comfortable, it is quite

acceptable to sit at one of the chairs at the table, if you would be more comfortable.

**Ms. Wood:** I am pretty stiff. I would rather stand up.

**Ms. Wasylycia-Leis:** Mr. Acting Chairperson, first of all, I would like to thank Elizabeth Wood for appearing before the committee and sharing an obviously difficult experience in helping us to understand better the whole issue of health consumer involvement in our system.

I am not going to get into the medical issue around Lyme disease. We have talked about it in Estimates. We need to talk about it again, but I think what is important here from your story is that we have all got to work very hard to shift the system from one that is so doctor-driven to one where consumers have a greater role.

I think that has to be behind any health care reform plan. I think your kind of situation, and the same with Mary James, tells us that there have to be some changes in the whole way in which decisions are made, the way hospital facilities run, the way doctors exercise authority, so that patients and health care consumers find some way to have their concerns listened to and have some say in their own treatment and their own health care needs.

Can you give us any advice in terms of where we should put our efforts in terms of the health care reform agenda to open up those doors and empower individuals?

**Ms. Wood:** We need to be able to definitely speak to the minister's office and be heard, for one. I am not saying that this bill is wrong or not a good thing. I am just concerned, considering what I have been through. I feel very helpless as a health care consumer.

I have been accused of many things, one being that I am a doctor shopper. If someone would have listened, a lot of this could have been prevented. Now we are going to have prolonged treatments on antibiotics—very expensive antibiotics. If someone had listened the day after my daughter was born, she could have been treated and cured. Now we do not know what the process will be. We need someone to listen to us.

**Mr. Cheema:** Ms. Wood, we have met with you many times. Your situation is not fairly unknown to most of the health care professionals you have dealt with, and you have gone through the college, you

have gone through the Health Services Commission and all of those things.

I am interested to know, you have told the committee that you have a communication from the Health Services Commission saying that if you go to this place, you will not be able to go to some other place. Can you provide us a copy of that letter, please?

**Ms. Wood:** I did not bring it with me, but I can provide it for you.

**Mr. Cheema:** Mr. Acting Chairperson, I think it is very important, because if that is a fact, then there is a major problem. You know and the Minister of Health (Mr. Orchard) knows, with the law, if your health care professionals are saying those services are not available in Manitoba, then they will send you either within the provinces or out of the country.

I would like to get a copy of that, and certainly then we will communicate with you. Thank you.

**The Acting Chairperson (Mr. Rose):** Ms. Wood, did you wish to comment?

**Ms. Wood:** I have a copy at home. I will xerox it and bring it in.

**Mr. Orchard:** Ms. Wood, you indicated at the start of your remarks that you have been diagnosed by two physicians from New Jersey?

**Ms. Wood:** One for my daughter, which is a pediatrician and neurologist, and one for myself, yes.

**Mr. Orchard:** Mr. Acting Chairperson, can I ask Ms. Wood, have you shared those diagnoses with physicians in Manitoba?

**Ms. Wood:** Yes, we have.

**Mr. Orchard:** Are they proceeding with a recommended therapy?

**Ms. Wood:** Well, my own physician told me that he would have to confer with our infectious-disease people, and usually at that point you run into trouble. Even though your family doctors will treat you, the infectious-disease people do not believe in the disease, so that is where the treatment stops.

My daughter's pediatrician said that he would wait until he got the letter, which is probably next week, and notify me then, but he promised me on the phone before I left New Jersey that he would treat her.

**Mr. Orchard:** Now, did the two physicians, the physician who diagnosed you and the pediatrician

who diagnosed your daughter, did they, in the course of the diagnoses and the discussion with you, suggest treatment regimes and what is available?

**Ms. Wood:** For myself, it would be an oral antibiotic similar to what they use for tuberculosis treatment. It is quite high-powered antibiotics, and usually a combination of two or three. Hopefully, over a period of a year or so, I will be able to be withdrawn from those drugs.

For my daughter, it was recommended that it would be anywhere from three to six weeks of intravenous antibiotics because of the neurological implications for a young child.

**Mr. Orchard:** Mr. Acting Chairperson, staff in my office have worked quite closely over the last three years I guess, three and a half years, with Ms. Wood and the unfortunate circumstance she finds herself and her family in. I am certainly pleased that the diagnosis from New Jersey was appropriate.

I think what I will ask of the commission is that, the referral cost would have been paid under ordinary circumstances but, with the condition as you outlined in the letter and given that you did not wish to agree to that condition in the letter, but the diagnosis has been positive, I am sure that we will arrange with the commission that you will be reimbursed as if you had agreed to the conditions of the letter.

**Ms. Wood:** The question is: Will I be reimbursed according to Manitoba standards?

**Mr. Orchard:** The reimbursement will be as we provide to all other Manitobans that we refer out of province.

**Ms. Wood:** The problem with that is, there is no treatment for Lyme disease here in Manitoba, and there is no diagnosis possible for a person that got it in Manitoba, so would I not be able to get, or would the commission not reimburse me for, the whole amount?

**Mr. Orchard:** Mr. Acting Chairperson, I probably erred in even mentioning what I did. We will comply with the regulations that we have. I am not in a position to discuss the medical condition because there is certainly a lot this year. You are well aware of controversy around the presence and diagnosis and treatment, and you are right.

Since this issue has been before the ministry for at least three or three and a half years, unresolved, I am pleased to see that you may be on the road to

resolution. Please appreciate, I am not defending the medical establishment that some would wish to say ought not to be involved in diagnosis of such disease, but the professional body of intelligence in Manitoba could not come to a conclusion, given their experience and circumstances around Lyme disease is medically known.

\* (1700)

I would not want committee to be left with the impression that the medical community, the ministry of Health and the citizens of Manitoba abandoned trying to find a solution to your medical problems. I think we have been trying for some three or three and a half years. I am appreciative of the fact that you may well have information that you can share with local physicians to attempt, within the medical knowledge available, to provide the appropriate treatment that will provide you relief. I am pleased with that, ma'am.

**The Acting Chairperson (Mr. Rose):** Ms. Wood, do you wish to comment?

**Ms. Wood:** I just want to thank the minister for taking this time. I do want to once again put the importance to the committee, saying that it is very important that we have input and that if a circumstance like mine comes up, do not leave it three years. Thank you.

**The Acting Chairperson (Mr. Rose):** Thank you very much, Ms. Elizabeth Wood.

The next presenter, Ms. Pat Cherter, private citizen. First of all, am I pronouncing your name correctly?

**Ms. Pat Cherter (Private Citizen):** Charter, like the Charter of Rights.

**The Acting Chairperson (Mr. Rose):** Charter? Okay, thank you. Please proceed.

**Ms. Cherter:** I will try and proceed in a very condensed manner. Several years ago I became the victim of a violent car accident. I was unconscious for three weeks and woke up to discover a whole new road of rehabilitation, one which I was going to journey. I have been on that road for eight years. I have countless volumes I could share with you.

However, knowing that there is concern regarding health care reform here, I wanted to mention my very, very valid concern that each patient who requires one have a patient advocate. I was in the hospital for a very long time. I was very anxious to

be discharged and spoke with the head nurse on my ward, who said she would investigate to see if this would be possible.

She came to me a week later and said, yes, it is being considered and that there would be a special meeting held to discuss the matter further, to which I said, where and what time? I certainly do not want to miss it. She said, oh, do not concern yourself. These meetings are not for patients, they are just for the professionals involved in your case. I was perplexed, and I said, pardon?

She said, well, right, all the professionals involved in your case, together with home care, will be present at the meeting.

So I said, just a minute, are you saying that this meeting will be with regard to my health care, regarding my future, and I would not be there?

Well, you need not be there, she said.

I said, I think you are forgetting the most important person of all: me. I want to be there.

The problem is, though, I cannot speak. You see, I have a trachea tube and I could not speak, so I pressed the trachea tube, and I said to the nurse, but I wonder if it would be okay if asked my patient advocate to speak on my behalf, and he did.

I am so grateful that he was there and able to speak for me. The meeting went well and, I am happy to say, I am here today and I can speak, softly, mind you, but nonetheless I can speak.

It is important that we give thoughtful consideration to two final components: firstly, that patients are allowed to participate in decisions of their own health care and well-being; secondly, that when possible always allow a patient advocate if they require one.

Thank you. Good health to all of you.

**The Acting Chairperson (Mr. Rose):** Thank you, Ms. Cherter. Would you care to respond to questions or comments?

**Ms. Wasylycia-Lels:** Again, I would like to thank Pat Cherter for being here all afternoon—it is getting quite late—and taking the time and having so much patience to wait to make a presentation to us on Bill 75.

You have raised another aspect of a very important part of health care reform and health consumer input into the whole system.

I would like to ask specifically about the issue of patient advocate. I know that your proposal through

the Manitoba Association for Rights and Liberties was very detailed in terms of a model and a system for patient advocates. Have you heard anything from the present minister or anyone in his department about the possibility of pursuing some system of patient advocate?

**Ms. Cherter:** No, unfortunately, I have not.

**Ms. Wasylycia-Lels:** As I understand it, this is an area that other jurisdictions are looking at very seriously and starting to move. I am wondering, do you have any advice in terms of the best way for government to proceed with respect to a system of patient advocates?

**Ms. Cherter:** Actually, the brief that was presented to the government outlined every area of patient advocacy. I would suggest that brief be examined and that the suggestions and recommendations be taken very seriously.

**Ms. Wasylycia-Lels:** I would assume based on your comments and your persisting in terms of this concept and idea that you would welcome a response from the Minister of Health (Mr. Orchard) and the government any day in terms of the feasibility of your proposal and government intentions with respect to some system of patient advocates.

I just wanted to conclude my remarks by indicating that we admire your persistence on this issue, Ms. Cherter, and hope that you will continue to pursue such matters. I think this is clearly an area where community organizations and citizens groups are ahead of government. I am not singling out one particular government. I think all parties have perhaps been slow to act in this regard over the years.

It is clear that as the whole health care reform agenda unfolds that it is imperative that we deal with health care consumer rights and we deal with some system of patient advocates.

Just as a closing remark, I am wondering if you could tell us how you intend to follow up and if you have any last-minute advice for us as we work to conclude matters around Bill 75.

**Ms. Cherter:** I might offer a warning. You used the word persistency a few times. I have to warn you, it is my favourite word. You see, I would not be walking today or speaking today if not for persistency. So for sure, I guarantee, I will persistently carry on with my hopes. Please know I am encouraged to think in this time of great financial

concern in our health care system that these suggestions will be taken very thoughtfully and considered very wisely. Thank you.

**Mr. Cheema:** Mr. Acting Chairperson, you talk about Ms. Cherter's persistency. I think it is worthwhile to point out to you that your concern, what you have raised, was 18 years ago. Now, things have changed a lot. I do not want to undermine what you are saying, but many things are being done.

Hospitals have advocacy rules and there is co-operative care in some hospitals where the patients are actually being involved in the whole issue and, with your knowledge in health care, if you would notice how the health care reform is coming along, there is more and more participation.

For a lawmaker it becomes very tough, and I am just speaking on my behalf here. To put each and every group's special role, I think the role of us is to make sure that the concern of all Manitobans are being heard. That can only be done if we have participation in the process of health care reform. I think things are happening in many positive ways.

The advocacy role, to put in a law, say that so-and-so person is responsible to speak on so-and-so issue for so-and-so hospital becomes very tough. It will be simply not practical. Certainly, the role of patients and their rights, I think you have heard about Bill 73. Bill 73 is another part of the advocacy giving rights to the patients and the dignity back to the patient.

So I want to just emphasize, many things are happening. It is not perfect, but many things are happening. It is your persistence probably in some ways helping us to implement those things. I just wanted to point out to you again that the co-operative care is one of the ways many hospitals are doing it. Thank you.

**Ms. Cherter:** I am very pleased to see that there are health care representatives within the hospital, for sure. We do, however, require an external health care advocate, for sure.

**The Acting Chairperson (Mr. Rose):** Thank you. Are there any further questions or comments from Ms. Cherter? Hearing none, I would like to thank you very much for your presentation.

**Ms. Cherter:** You are welcome.

\* (1710)

**The Acting Chairperson (Mr. Rose):** I would like to thank all presenters for their patience and their contribution to the committee. Are there any other presenters for the bills before us this afternoon? Hearing none, we will move into consideration of the bills.

Does the committee wish to consider the bills in sequential order?

### **Bill 71—The Retirement Plan Beneficiaries Act**

**The Acting Chairperson (Mr. Rose):** Does the minister responsible for Bill 71 have an opening statement?

**Hon. James McCrae (Minister of Justice and Attorney General):** Bill 71 is a very, very brief one. We want to validate designation-of-beneficiary forms. We believe that will benefit all Manitobans who make use of them. Generally, individuals who make use of these forms believe they are valid, and this act would give effect to that belief. Thank you, Mr. Acting Chairperson.

**The Acting Chairperson (Mr. Rose):** Does the critic for the official opposition party have an opening statement? Does the critic for the second opposition party have an opening statement?

**Mr. Gulzar Cheema (The Maples):** That is fine.

**The Acting Chairperson (Mr. Rose):** The bill will be considered clause by clause. During the consideration of the bill, the Title and the Preamble are postponed until all clauses have been considered in their proper order by the committee.

Clause 1—pass; Clauses 2 to 7—pass; Clauses 8 to 14—pass; Clauses 15 to 21(2)—pass; Preamble—pass; Title—pass. Bill be reported.

### **Bill 73—The Health Care Directives and Consequential Amendments Act**

**The Acting Chairperson (Mr. Rose):** Does the minister responsible for Bill 73 have an opening statement?

**Hon. James McCrae (Minister of Justice and Attorney General):** Bill 73, Mr. Acting Chairperson. I think a lot has been said about this bill already. There seems to be a fair amount of support in the Legislature and in the public for the principles underlying this bill.

When we get to the appropriate points in our clause by clause, I propose to bring forward one

amendment to deal with the dating of these health care directives and another amendment to deal with an amendment, by your leave, Mr. Acting Chairperson, to The Human Tissue Act. Those are the amendments we propose to be bringing forward today.

**The Acting Chairperson (Mr. Rose):** Does the critic for the official opposition party have an opening statement?

**Mr. Dave Chomiak (Kildonan):** Mr. Acting Chairperson, basically my comments will be short, just to indicate that we support this legislation. We think it is a positive step. We basically commend the government on the introduction and accordingly are supportive of the act. We do not think that an act of this kind can be introduced without some difficulties, and there will be some difficulties which will occur.

There are several questions we have with respect to the act and some of the specific workings of the act which we would like to raise. There may be some other suggestions we have for the government with respect to improving the act. We certainly think that as it develops the act will probably require some changes.

We are quite concerned, and we put these comments on the record at second reading, with respect to the fact that this bill has long-term ramifications for all members of the public in the province and that an education program will have to be undertaken in order to inform Manitobans about this change in the way we approach health care.

Accordingly, I think some of the suggestions made by some of the presenters should be taken in mind by the ministers with some of the very innovative suggestions that were made by the presenters. I am thinking specifically of some of the suggestions of Mr. Oldham in terms of how this information is communicated to the public.

Generally, other than specific points and issues that we will be raising as we go through the bill, those will complete my comments.

**The Acting Chairperson (Mr. Rose):** Does the critic for the second opposition party have an opening statement?

**Mr. Gulzar Cheema (The Maples):** Mr. Acting Chairperson, I would like to commend the government for bringing this bill, Bill 73 in the similar image of Bill 16.

First, in this country, and I think a lot has been said, and I also point out to the committee the work by the Law Reform Commission which has actually done all the work. All the presentations have already been made. It has been four years, six years work. That is why a bill of such magnitude, that did not have many presentations, that does not mean there is no interest. The interest is there. Most people know what is happening. I just want that to be pointed out.

All individuals in the Law Reform Commission have done a good job putting this bill forward. It was a tough job, and again, reaffirming our support for the basic individual rights and the dignity of the patient which this bill is going to achieve.

There could be some problem when we have this bill actually practised in terms of real life. I think we can come back, if there is any problem, it can be addressed in the next year or so. It will be a model for the rest of the country to have a look. Already there are individuals from—I know—from B.C., who want to have a similar bill, a private members' bill, even want to bring and take a lead to make sure that the rights of patients, specifically after Nancy B.'s case, everyone wants to do the right thing for the patient.

I would certainly end my remarks. I have two amendments, and I will bring them forward. They are very minor, and certainly will clear one or two definitions.

Again, expressing our sincere thanks to the many individuals who have written to me personally and to our caucus. There are a large number of people I would like to mention, but the time is very short. I certainly want to express to the minister, that most of the organizations were in favour of this bill. They wanted it to be passed and come to the real issue of practical application of this bill.

With that, Mr. Acting Chairperson, we would like to proceed.

**The Acting Chairperson (Mr. Rose):** Considering that we will have proposed amendments, perhaps, we will proceed clause by clause, if that is agreeable with the committee. Agreed. As usual, the Title and Preamble are postponed until all clauses have been considered in their proper order.

Clause 1—pass; Clause 2—pass; Clause 3—pass; Clause 4(1)—pass; Clause 4(2)—pass; Clause 4(3)—pass; Clause 5—pass; Clause 6(1)—pass; Clause 6(2)—pass; Clause 7(1)—pass; Clause 7(2)—pass.

Clause 8(1).

**Mr. McCrae:** As I stated earlier, I intended to move an amendment respecting the dating of these health care directives, and I move, in the English and French languages

THAT subsection 8(1) be amended by adding "and dated" after "in writing".

**[French version]**

Il est proposé que le paragraphe 8(1) soit amendé par adjonction, après "par écrit", de "et comporter une date".

**The Acting Chairperson (Mr. Rose):** It has been moved by Honourable Mr. McCrae, that Subsection 8(1) be amended by adding "and dated" after "in writing".

\* (1720)

**Mr. Chomiak:** Mr. Acting Chairperson, I have a question for the minister, not on the amendment that he is proposing, but on just this subsection.

When the amendment states "in writing", can the minister inform me specifically what that means? We know that in terms of interpretation of wills and interpretation of holograph wills in Manitoba, there is some question of whether it is in the person's own handwriting and the like. I am wondering what the legal opinion might be in terms of the definition of what "in writing" should mean.

**Mr. McCrae:** Mr. Acting Chairperson, the advice that I have received is that common law principles will apply along with this legislation, so that the example referred to by one of the presenters about previous health care directives that have been put together prior to the passage of this legislation and undated, is not rendered invalid by virtue of the fact we are putting the words "and dated" in this legislation.

That is the advice I have received, that while we want to see—I guess it is another piece of evidence about the validity of a health care directive. If there is a question, for example, in the case of someone who moves from a condition of competence to incompetence and to competence again, the date could become an important matter. It certainly becomes a useful tool to any court or anyone who is having to answer questions as a result of questions being raised about a health care directive. That is the advice I have received, and I am about to get a little bit more, so you might hold on there for a minute.

I think the honourable member was also asking about what "in writing" means. I think that means you can have a holograph, you can have it in writing or you can have it in typed form or run through an IBM printer or you could scratch it on something with something else—as long as it was something that could be read.

**Mr. Chomiak:** I thank the minister for those two responses. My only question then is the key factor will be that it must be signed personally, therefore, by the maker.

**Mr. McCrae:** If the honourable member looks at Section 8(2), he will see that it can also be done by somebody else, but the person would have to be present, is my understanding, for that to happen. There were days when people could not write, and there still are, unfortunately, and—for physical reasons or for reasons of perhaps illiteracy, so that those rules from time immemorial I guess would still apply to those types of situations.

**Ms. Judy Wasylycia-Lels (St. Johns):** Just on a related matter, and that is the concern raised by MARL on formal compliance versus substantial compliance. Is the minister saying that given common law, that one would not need to spell out in this law, as we have in The Wills Act, the fact that where formal compliance is not met, that substantial compliance would be acceptable?

**Mr. McCrae:** Mr. Acting Chairperson, when I say that common law principles apply, what I mean is, this legislation is drafted in such a way that really what we are trying to get at is the intent of the person who wants to have his or her wishes followed.

We put minimum kinds of requirements in this legislation so that you can do it with your Philadelphia lawyer if you want, or you can do it at home by yourself with your family, if you want. We have tried to keep those legal requirements to a bare minimum here, but the idea is to try to ascertain the intent of the person making one of these living wills.

**Ms. Wasylycia-Lels:** I raised the issue because, in fact, we heard from two different ends of the spectrum this afternoon, one group calling for more specific delineation of what a directive is, and another group saying, keep it as loose as possible.

We are adding, although it is not that much, but we are adding something, and that is dating the directive. I guess my concern is what does this mean then if it is not dated, it will be invalid.

**Mr. McCrae:** I am advised in a technical sense it will be invalid with this amendment if it is undated, but this legislation does not override the common law of this land, so that you have both operating at the same time.

When I say that we are trying to make this as uncomplicated as we can, I mean I think that is a fine intention, but it seems that life is getting more and more complex all the time. I hope we will not be back here building in further language in the future that will really only have the effect of putting the lawyers to work again. We really want to make this as simple as we can. As Dr. Cheema has said, we may well be back at some point as we watch this legislation perform, but I am hoping that will not be the case too.

**The Acting Chairperson (Mr. Rose):** The proposed amendment to subsection 8(1)—pass; Clause 8(1) as amended—pass; Clause 8(2)—pass; Clause 9(1)—pass; Clause 9(2)—pass; Clause 10—pass; Clause 11—pass; Clause 12—pass.

Clause 13.

**Mr. Cheema:** Mr. Acting Chairperson, there was a concern expressed to have a form developed, sort of guidelines developed for a prescribed form of direction and that was a part of the Manitoba Law Reform Commission report also. I just want to know whether we are going to have that put in place here to make sure there is some form which are basic guidelines to make sure we have a uniform deal in the system.

**Mr. McCrae:** It is intended, Mr. Acting Chairperson, that sample forms of directives would be published in regulations from time to time as a guide to potential makers, but their use would be entirely voluntary.

**The Acting Chairperson (Mr. Rose):** Clause 13—pass; Clause 14—pass; Clause 15(1)—pass; Clause 15(2)—pass; Clause 15(3)—pass; Clause 16—pass; Clause 17(1)—pass.

Clause 17(2).

**Mr. Cheema:** Mr. Acting Chairperson, I have an amendment for Clause 17(1)(b). I move,

THAT clause 17(1)(b) of the Bill be amended by striking out "another" and substituting "at least one other".

[French version]



Il est proposé que l'alinéa 17(1)(b) du projet de loi soit amendé par substitution, à "un autre mandataire", de "au moins un autre mandataire".

**The Acting Chairperson (Mr. Rose):** Just before I accept the amendment, I believe that we had already passed Clause 17 in our haste. Is it the agreement of the committee to move back and reconsider the amendment? We will then reconsider Clause 17(1).

The proposed amendment moved by Dr. Cheema is that the Clause 17(1)(b) of the bill be amended by striking out "another" and substituting "at least one other".

\* (1730)

**Mr. McCrae:** Could I, Mr. Acting Chairperson, just ask Dr. Cheema for a very brief explanation. This looks like an amendment that we find we do not have much problem with, but the honourable member could change my mind if he is not careful.

**Mr. Cheema:** Mr. Acting Chairperson, I will explain it to you. I will try, with my usual language barrier, but I will try.

Basically, the intent of this amendment is if there is more than one proxy—two or three—and saying that "another" proxy, and just simply clarifying where there is at least one other proxy. This would simply, by the way of wording the section, and it is not going to have major changes. We just want to make sure that if there are one, two, three, it is specified and say one rather than another.

**Mr. McCrae:** With that explanation I, speaking for myself, can say that I do not have any problem with that.

**The Acting Chairperson (Mr. Rose):** The amendment moved by Dr. Cheema to Clause 17(1)(b) has been moved in both official languages—pass; Clause 17(1) as amended—pass; Clause 17(2)—pass; Clause 18—pass; Clause 19—pass; Clause 20—pass.

Clause 21.

**Mr. Chomlak:** Mr. Acting Chairperson, during the course of presentations there was some legal opinion offered on the effect of Clause 21 and the onus that it placed on a health care professional or other person.

The suggestion was that the presence of Section 21 meant that the common law requirement on a health care professional or other person to inquire into certain new information by virtue of this clause,

the common law provision that would require a person to make reasonable inquiry, I presume, is no longer in effect because of this statutory override, if I can interpret what was said at the presentation correctly. I am wondering if we might have some comment on that particular viewpoint.

**Mr. McCrae:** Mr. Acting Chairperson, the onus is on the maker to let others know about the existence or revocation of his or her directive. No one else is under any obligation to check. As a result, no one is liable for failing to act in accordance with a directive if he or she did not know of its existence. We do not want, by passing legislation like this, to create a whole new level of potential liability. That is not the purpose of a living will.

I think the question that the honourable member is asking goes more to the education that goes with this kind of a program, goes with the education that perhaps the government or perhaps the MMA, people in the health care industry ought to be advised that these things now are the subject of legislation in Manitoba. I would be encouraging health care professionals to be making that inquiry, but we do not want to set up a whole new regime of liability that someone should have checked. In order for that to happen, we felt this kind of language in the legislation was required.

**Mr. Chomlak:** Basically, I agree with the minister in terms of ascendments, but I guess I am forced to discuss this further because of the comment made by one of the presenters who in fact I believe is a lawyer. The point that was made is that this particular clause removes any responsibility essentially from anyone to inquire in any stretch or during any course of any kind of treatment.

**Mr. McCrae:** Well, the honourable member is right about that, but what about the practicalities of the operation of the practice of medicine, for example? My experience with health care professionals, if it is the same as the honourable member's which I am sure it is, is that these people are here to help.

If it would help alleviate problems, pain, suffering or if it would help to know the wishes of the patient involved, I do not know of a single health care person in this province who would not, in consultation with a known proxy or family members or whomever, want to be finding out all the things that are appropriate to know in order to arrive at the best kind of health care regime for the patient. I think we have to be careful we do not get mixed up with legalities and practicalities.

It seems to me the practicality of the health care system says that you find out these kinds of things. I see my colleague may have something to add and Dr. Cheema as well.

**Hon. Donald Orchard (Minister of Health):** The section, as I read it, is very specific in that there is not a requirement on, for instance, a physician to ask of the existence of a directive as empowered by this act.

That does not prevent the physician from asking next of kin or everyone if there was an advance care directive. By having this clause in there, there is no knowledge by the caregiver of the existence, because it was not volunteered, it was not asked for, that there is then created a legal obligation against the physician for either forgetting to ask or not asking or choosing not to ask. Nothing in here prevents the physician from asking if nothing compels him that he must ask for the reasons shared by the Justice minister.

I think it adds to the user friendliness and acceptability of the living will without creating yet another opportunity for—I do not know if this language would be appropriate—but wrongful challenges based on this legislation and the existence or nonexistence of an advance directive.

**Mr. Cheema:** I have a concern with this because, if we are going to remove that or the proposal is to reinforce that the physician or the health care provider must inform the patient, I think we are putting a responsibility too much on the health care providers. It should be a responsibility of individuals to have—and the government can educate them of what is available.

Forcing something on health care providers is not going to be practical because, first of all, that means if a patient is visiting in a given hospital, and the patient goes there, does not have a proxy and, if the hospital is not aware of the proxy, is the hospital going to be liable for a legal suit in the long run? It could happen. If you have two physicians, who is going to be ultimately responsible to know that?

If you are in a personal care home or you are changing your status or you are changing your doctor, I think it will cause problems. Also, if we accept this in case, that means that there has to be change in the regulation in terms of, the college's own regulation has to be changed. That means the ethical physician definition then has to add another line, that the physician must inform.

That means every time they have to inform everyone: Do you have a health care proxy, if not, are you going to get this? I do not think that is the role of a health care professional. It is the role of the individual citizen to know what is available and make best use of those resources.

**Mr. McCrae:** Mr. Acting Chairperson, the Law Reform Commission itself might be quite helpful at this time. It looked at this very question.

I would just like to quote very briefly from its report on page 19: We also considered requiring health care professionals and health care facilities to inquire into whether a patient has made or revoked a health care directive, but decided against this also. Aside from the practical difficulties, some patients may arrive unconscious or in some other condition precluding communication. It seems to us more appropriate that the onus for publicizing the existence or revocation of a health care directive rest on the person who wishes it to be given effect, the maker. To this end, individuals should be encouraged to inform their families and physician about their health care directive or its revocation and to carry a copy on their person.

I believe the Law Reform Commission has got it right on this point.

\* (1740)

**Mr. Chomiak:** The minister indicated earlier in his comments that the onus is on the individual. That is not any kind of a statutory requirement, that is simply what the minister is saying and, in fact, that is not even common law. That is simply common sense. Is that not the case? There is no legal requirement on the individual to inform. That is correct?

**Mr. McCrae:** Mr. Acting Chairperson, it seems to me, it is like making any other will. You can write out a will and then go and hide it somewhere and, really, what good is it? Is someone supposed to say, well, you know, we are not going to look after this estate until we have actually found a will that nobody even knows exists? That is taking it to the ridiculous, I suppose, but I think that is the kind of comparison we are making here.

**Mr. Chomiak:** One of the concerns that could be proposed with respect to this section is the question of an individual who had written a directive and subsequently became incompetent and then was transferred from facility to facility. At that point, the individual has lost the ability to express or have any

ability to effect decisions and to effect whether or not that notification is made. That would, therefore, require facilities to make reasonable and prudent inquiries on most occasions when the transfer is effective.

I just wonder if either of the ministers want to comment on that. What I am saying is it is not going to be exclusively and entirely up to the individual in cases where it is out of the individual's hand. That is the point I am making.

**Mr. Harold Neufeld (Rossmore):** Surely, it is not our intention to pass legislation that would create additional responsibilities for the caregivers. This is what it would do if we take this out. It would open the door, I believe, to a host of lawsuits because of the reasonableness of the questions that might have been asked.

**Mr. Orchard:** Mr. Acting Chairperson, if I listen to some of the stated positions in response to presenters, I believe the New Democrats were wanting patient empowerment and patient responsibility, more patient proactive response to deciding their own treatment and care regimes. That is exactly what this act is designed to empower. We are trying to do it without opening up Pandora's box of frivolous legal challenges because of this act.

If you leave in there a requirement for the caregiver or the facility to ask of the existence of a directive, you will create a legal onus and the challenges, et cetera. This is in there to give the empowerment to the patient that my honourable friend has talked about all afternoon—nothing more, nothing less.

**Mr. Cheema:** Mr. Acting Chairperson, I just want to add one more line here, because what this bill has to do is to improve the quality of life and dignity of patients. If we are going to try to make physicians act as lawyers and try to give them another added responsibility which they are not trained for, I think we are asking too much. That is why I want to make it very clear that this bill has to take care of individuals and not give any extra responsibility to the health care professionals.

**Mr. Chomiak:** Mr. Acting Chairperson, you know, very rarely do I get involved in adversarial debates in matters of this kind, but precisely the reason—we have simply been asking questions and querying on certain aspects of the law.

The fact that people have jumped to defend a position and to somehow imply that we were

somehow proposing a change to the act only perhaps to me indicates a need in this area too to provide some kind of direction, because it seems to me that in order to cut through this and try to determine where it can go and what it can do, we have already had—if I was a poor patient in the system now, I can imagine how they might feel under certain circumstances.

I might add that litigation in this area is extensive. I am not completely familiar, but I am somewhat familiar with this area. Certainly it can get very, very complicated, but the point is that we are making queries, and what I am getting at certainly the last several responses are defensive responses to queries, which indicates to me there might be a legitimate point that might be had.

**Mr. Orchard:** Dave, you are not satisfied with the answer. That is your problem.

**Mr. Chomiak:** No.

**Mr. McCrae:** Only when the member is finished.

I hope the honourable member is not including me in his criticism. I did not think I was being adversarial. Certainly other members of this committee can speak for themselves, but for my part, I felt the honourable member was engaging in a discussion here, not necessarily pressing any particular point.

I heard the representatives from the Medical Association here. I think they commented on this aspect of it either in response to a question or without any question. What they are saying is that they support very, very much this legislation, but they like that clause the way it is, too.

I think that if the Medical Association is going to be very much part of whatever education program is going to be undertaken in the future, and I do not know how you can do it without the MMA, frankly, I believe in a very—maybe this is a political view of it—but we need the medical profession to support this bill. We need them also to help educate their members on the operation of this bill. So for that reason, too, we need their co-operation.

While I still think the merits of the arguments are all in favour of this clause as it is written, there is another very good reason to leave it that way, and that is, we need the co-operation of the health care professionals to make sure that they and the people they are working with are very much up on what is in this bill. That is a very key element of the education program, I suggest.

**The Acting Chairperson (Mr. Rose):** Shall Clause 21 pass?

**Mr. Cheema:** Mr. Acting Chairperson, I just want to have a few minutes. The member for Kildonan (Mr. Chomiak) should not feel upset because, while this bill was being drafted at the Manitoba Law Reform Commission, extensive research has been done. Those concerns were raised. When I was talking to individuals, those concerns were very much raised.

This is the basic problem, that you cannot force any profession to do something which is not part of their job. Simply, we are putting too much responsibility on a professional caregiver to do something which they are not supposed to be. I think it is the responsibility of all of us to take care of some of our daily activities, and that includes our living will also.

**Ms. Wasylycia-Lels:** Yes, I just wanted to ask another question around this, because in fact we have raised this because it has been brought to our attention by several presenters.

We were left with the impression that the inclusion of Section 21 actually is almost a disincentive or a discouragement in terms of professionals inquiring about whether or not there is a directive. The suggestion was made that the deletion of 21, I thought they were saying it would not necessarily create any new regime in terms of litigation and that common law precedents would apply and that in fact it would do what the Minister of Justice is saying it should do, and that is respect the want of all health care professionals to care and therefore to ask those questions.

I guess there is a bit of a difference around the table, but I think the Minister of Justice is more reflecting where we are coming from, and that is, we want to ensure in legislation that nurturing, caring professionalism where you would automatically ask the question is allowed to happen without creating a new set of litigation and a whole bunch of lawsuits.

**Mr. McCrae:** I agree wholeheartedly with the result the honourable member and her colleague wants to achieve here. That is why we have this bill in front of us. I say, I am advised that the deletion of this clause would create a legal ambiguity which is real fodder for litigation, and that is not what we are trying to create here. We are trying to create something practical that people can work from. We are not trying to create a new sidewalk to the courthouse.

\* (1750)

**The Acting Chairperson (Mr. Rose):** Clause 21—pass.

Clause 22.

**Mr. Cheema:** Mr. Acting Chairperson, I have an amendment for Clause 22, and I move

THAT section 22 of the Bill be amended by striking out clause (a) and substituting the following:

a) has acted in good faith in accordance with the wishes expressed in a directive, or in accordance with a decision made by a proxy that is not contrary to the wishes expressed in a directive;

[French version]

Il est proposé que l'article 22 du projet de loi soit amendé par substitution, à l'alinéa a), de ce qui suit:

a) d'avoir agi de bonne foi et conformément aux volontés précisées dans des directives ou aux décisions d'un mandataire qui ne vont pas à l'encontre des volontés précisées dans les directives;

Mr. Acting Chairperson, that goes along with what the recommendation was in the Law Reform Commission.. They are simply reinforcing the fact that the health care provider must take all the precautions to check that the wishes of the individual are being met, and simply reinforcing that aspect.

**Motion presented.**

**Mr. McCrae:** There is a problem and I hate to say so. This clause was apparently in the recommendations of the Law Reform Commission, but because Section 13 was put in here, in the legislation before us, we find those two sections in a conflict. That is the legal explanation; otherwise, what the honourable member is proposing would be all right.

If we accept Clause 13, which I think we do, which we have already passed, then we have a problem with this amendment. For that reason, I either would ask the honourable member to withdraw or then I would not want to have to vote against it.

**Mr. Cheema:** Mr. Acting Chairperson, I will withdraw that.

**The Acting Chairperson (Mr. Rose):** It is the consent of the committee to withdraw the amendment? Agreed.

Clause 22—pass; Clause 23—pass; Clause 24—pass; Clause 25—pass; Clause 26—pass; Clause 27—pass; Clause 28(1)—pass.

Clause 28(2).

**Mr. McCrae:** Do we have a 28(2)? We have to let that pass too, do we not? Sorry, we will let that one go as well and then 3.

**The Acting Chairperson (Mr. Rose):** Clause 28(2)—pass; 28(3)—pass; Clause 28(4)—pass; Clause 28(5)—pass; Clause 28(6)—pass; Clause 28(7)—pass; Clause 28(8)—pass; Clause 28(9)—pass; Clause 28(10)—pass; Clause 28(11)—pass; Clause 28(12)—pass; Clause 28(13)—pass; Clause 28(14)—pass; Clause 28(15)—pass; Clause 28(16)—pass; Clause 28(17)—pass; Clause 28(18)—pass; Clause 28(19)—pass.

Clause 29.

**Mr. McCrae:** I have an amendment that, unfortunately, has a lot of words in it, Mr. Acting Chairperson, but I will move it in both languages, French and English. I move,

THAT the following be added after section 28:

Consequential amendments, C.C.S.M. c.H180

**28.1(1)** The Human Tissue Act is amended by this section.

**28.1(2)** Section 1 is amended by adding the adding the following definition in alphabetical order:

“proxy” means a proxy appointed in a health care directive made in accordance with The Health Care Directives Act, but does not include a proxy to the extent he or she is restricted, by the terms of the directive, from making decisions that fall within the scope of the this Act; (“mandataire”)

**28.1(3)** Subsection 3(1) is repealed and the following is substituted:

**Direction on behalf of deceased person**

**3(1)** Where a person who dies

- (a) has not made a direction under section 2;
- (b) has made a direction under section 2 that by virtue of clause 2(3)(b) cannot be acted upon; or
- (c) is under 16 years of age;

a person described in subsection (1.1) may direct that the deceased person’s whole body, or any tissue or specified tissue from the deceased person’s body, may be used for therapeutic

purposes or for purposes of medical education or medical research.

**Direction by proxy or nearest relative**

**3(1.1)** A direction may be given under subsection (1)

- (a) by the deceased person’s proxy, if the deceased person was 18 years of age or over at the time of death;
- (b) if there is no proxy authorized to act or the proxy is unavailable, by the deceased person’s nearest relative; or
- (c) if there is no nearest relative or the nearest relative is unavailable, by the person lawfully in possession of the body or the Inspector of Anatomy, as the case may be.

**28.1(4)** Subsection 3(3) is repealed and the following is substituted:

**Direction on behalf of dying person**

**3(3)** Where a physician is of the opinion that a person

- (a) who has not made a direction under section 2; or
- (b) who has made a direction under section 2 that by virtue of clause 2(3)(b) cannot be acted upon;

is incapable of making a direction under section 2 and that the person’s death is imminent and inevitable, a person described in subsection (3.1) may direct that the dying person’s whole body, or any tissue or specified tissue from the dying person’s body, may be used after death for therapeutic purposes or for purposes of medical education or medical research.

**Direction by proxy or nearest relative**

**3(3.1)** A direction may be given under subsection (3)

- (a) by the dying person’s proxy, if the dying person is 18 years of age or over; or
- (b) if there is no proxy authorized to act or the proxy is unavailable, by the dying person’s nearest relative.

**28.1(5)** Subsection 4(2) is repealed and the following is substituted:

**Request after consideration**

**4(2)** A physician who determines that it is appropriate to request permission under subsection (1) shall, as soon as practicable after the death of the person but subject to subsection (3), request

permission to use the body of the deceased person for therapeutic purposes, or to remove tissue from the body to be used for therapeutic purposes,

(a) from the deceased person's proxy if the deceased person was 18 years of age or over at the time of death; or

(b) if there is no proxy authorized to act or the proxy is unavailable, from the deceased person's nearest relative.

**28.1(6)** Subsection 8(3) is repealed and the following is substituted:

**Participation in transplant prohibited**

**8(3)** A physician who participates in

(a) a determination of death under subsection (1); or

(b) the withdrawal or withholding of life-prolonging medical treatment in accordance with a health care directive made under The Health Care Directives Act;

in respect of a person from whose body tissue is to be removed for a proposed transplant shall not participate in the transplant operation.

**[French version]**

Il est proposé qu'il soit ajouté, après l'article 28, ce qui suit:

Modification du c.H180 de la C.P.L.M.

**28.1(1)** Le présent article modifie la Loi sur les tissus humains.

**28.1(2)** L'article 1 est modifié par adjonction de la définition suivante selon l'ordre alphabétique:

**"mandataire"** Mandataire nommé dans des directives faites en vertu de la Loi sur les directives en matière de soins de santé. La présente définition ne vise un mandataire que dans la mesure où il n'est pas restreint, en vertu des directives, dans la prise de décisions visées par la présente loi. ("proxy")

**28.1(3)** Le paragraphe 3(1) est remplacé par ce qui suit:

**Directives pour le compte d'un défunt**

**3(1)** Lorsqu'une personne décède, la personne visée au paragraphe (1.1) peut donner des directives pour que le corps du défunt, ou tout tissu ou un tissu particulier du corps puisse être utilisé à des fins thérapeutiques ou à des fins d'enseignement ou de recherche dans le domaine médical si l'une des conditions qui suivent s'applique:

a) Le défunt n'a pas donné de directives en vertu de l'article 2;

b) les directives données en vertu de l'article 2 ne peuvent être respectées pour le motif visé à l'alinéa 2(3)(b);

c) le défunt est âgé de moins de 16 ans.

**Directives—mandataire ou plus proche parent**

**3(1.1)** Des directives peuvent être données en vertu du paragraphe (1), selon le cas:

a) par le mandataire du défunt si ce dernier était âgé d'au moins 18 ans au moment du décès;

b) par le plus proche parent du défunt si aucun mandataire n'a été nommé ou s'il n'est pas possible de rejoindre le mandataire;

c) par la personne légalement en possession du corps ou par l'inspecteur de l'Anatomie, selon le cas, en l'absence de plus proches parents ou s'il n'est pas possible de rejoindre le plus proche parent.

**28.1(4)** Le paragraphe 3(3) est remplacé par ce qui suit:

**Directives—décès imminent**

**3(3)** Si le médecin est d'avis qu'une personne est incapable de donner les directives mentionnées à l'article 2 et que son décès est imminent et inévitable, la personne mentionnée au paragraphe (3.1) peut donner des directives pour que le corps du mourant ou tout tissu ou un tissu particulier du corps du mourant puisse être utilisé, après sa mort, à des fins thérapeutiques ou à des fins d'enseignement ou de recherche dans le domaine médical si l'une ou l'autre des conditions qui suivent s'applique:

a) la personne n'a pas donné de directives en vertu de l'article 2;

b) les directives données en vertu de l'article 2 ne peuvent être respectées pour le motif visé à l'alinéa 2(3)(b).

**Directives—mandataire ou plus proche parent**

**3(3.1)** Des directives peuvent être données en vertu du paragraphe (3), selon le cas:

a) par le mandataire du mourant si ce dernier est âgé d'au moins 18 ans;

b) par le plus proche parent du mourant si aucun mandataire n'a été nommé ou s'il n'est pas possible de rejoindre le mandataire.

**28.1(5)** Le paragraphe 4(2) est remplacé par ce qui suit:

**Demande**

4(2) Le médecin qui juge opportun de demander la permission visée au paragraphe (1) demande, sous réserve du paragraphe (3) et dès que possible après le décès, à l'une des personnes suivantes, selon le cas, la permission d'utiliser le corps du défunt, ou d'en prélever des tissus, à des fins thérapeutiques:

- a) le mandataire du défunt si ce dernier était âgé d'au moins 18 ans au moment du décès;
- b) le plus proche parent du défunt si aucun mandataire n'a été nommé ou s'il n'est pas possible de rejoindre le mandataire.

28.1(6) Le paragraphe 8(3) est remplacé par ce qui suit:

**Interdiction de participer à la transplantation**

8(3) Le médecin qui participe à l'une des décisions suivantes à l'égard d'une personne dont des tissus seront prélevés à des fins de transplantation ne peut participer à la transplantation:

- a) la détermination du moment du décès en vertu du paragraphe (1);
- b) le retrait ou la non-administration, en vertu de directives faites en application de la Loi sur les directives en matière de soins de santé, d'un traitement médical permettant de prolonger la vie.

Mr. Acting Chairperson, that is the amendment that I move, and I would like to give a much briefer explanation than the amendment itself.

\* (1800)

**Mr. Acting Chairperson (Mr. Rose):** Before you proceed, I am advised that the amendment is out of order because it is beyond the scope of the bill. However, if the committee gives its unanimous consent for consideration, it can be moved and considered and passed.

Do we have unanimous consent? It is agreed.

**Mr. McCrae:** I thank members of the committee. They already know what it is. Otherwise they would not have given their unanimous consent.

It has to do with The Human Tissue Act. This amendment makes consequential amendments to The Human Tissue Act, which were recommended by the Law Reform Commission. A proxy appointed in a health care directive by an adult will be able to authorize tissue donation after death for therapeutic purposes, medical education or medical research unless the directive restricts the proxy from making such decisions.

Presently such decisions are made by a person's nearest relative. To avoid the possibility of conflict of interest, a physician who is involved with withdrawing or withholding life-prolonging medical treatment with respect to a tissue donor in accordance with that person's health care directive or the instructions of a proxy will be prohibited from participating in the transplant operation.

**Mr. Chomlak:** I assume from the minister's comments that these had been previously recommended by the Law Reform Commission and had not been included in this particular version.

**Mr. McCrae:** That is the indication. The problem was that you cannot really do it by the rules what we are trying to do without the unanimous agreement of the members of the committee. So this does follow the Law Reform Commission's recommendation.

**Mr. Chomlak:** The one question I have is, for ethical reasons, there is a separation between the physician who determines the death and the withdrawal and the physician who undertakes the transplant. Is this standard under The Human Tissue Act? Is this sort of a standard procedure?

**Mr. McCrae:** It is consistent, Mr. Acting Chairperson. Under The Human Tissue Act, a physician who participates in a determination of death, in other words involved in the signing of a death certificate, is prohibited from participating in an organ transplantation from that person, from that deceased.

**Ms. Wasylycia-Lels:** I just have two questions. Number 1, what is Clause 2(3)(b)? I am trying to figure out what 3(1)(b) means. There is a qualifier on—

**Mr. McCrae:** This subsection is there so that we do not transgress the provisions of The Human Tissue Act.

**Ms. Wasylycia-Lels:** Without taking up time and asking for exactly what Clause 2(3)(b) is, let me just ask if the minister can assure us, through these amendments, that health care directives and proxies, as outlined in Bill 73, take priority or precedent over The Human Tissue Act.

**Mr. McCrae:** I hope I am answering the honourable member's question, but the proxy under this legislation would be the person who can make decisions under The Human Tissue Act rather than the nearest relative. That is what this does. It

makes the proxy the person who can speak for what happens to the remains.

**The Acting Chairperson (Mr. Rose):** The proposed amendment to Bill 73—pass.

Clause 29.

**Mr. Orchard:** Mr. Acting Chairperson, I just want to thank my honourable colleagues in both opposition parties for expedition of this last significant amendment, which I think was very well advised.

**The Acting Chairperson (Mr. Rose):** Clause 29—pass; Clause 30—pass.

**Mr. McCrae:** I have a motion, Mr. Acting Chairperson. I move, in both languages, French and English,

THAT Legislative Counsel be authorized to change all section numbers and internal references necessary to carry out the amendments adopted by this committee.

**[French version]**

Il est proposé que le conseiller législatif soit autorisé à modifier les numéros d'article et les renvois internes de façon à donner effet aux amendements adoptés par le Comité.

**The Acting Chairperson (Mr. Rose):** All those in favour of the motion please say yea.

**Some Honourable Members:** Yea.

**The Acting Chairperson (Mr. Rose):** All those opposed please say nay. The motion is carried.

Preamble—pass; Title—pass; Table of Contents—pass; Bill be reported.

\* (1810)

### **Bill 75—The Health Services Insurance Amendment and Consequential Amendments Act**

**The Acting Chairperson (Mr. Rose):** Does the minister responsible for Bill 75 have an opening statement?

**Hon. Donald Orchard (Minister of Health):** Mr. Acting Chairperson, I just want to thank my honourable friends on both sides of the House for their support of this legislation.

**The Acting Chairperson (Mr. Rose):** Does the critic for the official opposition have an opening statement?

**Ms. Judy Wasylycia-Lels (St. Johns):** Yes, Mr. Acting Chairperson, a few brief opening comments.

First of all, as the minister has acknowledged and recognized, the New Democratic Party, in second reading, had given general support for Bill 75. Our position has not changed. We believe that these are important administrative changes to amalgamate the Department of Health and the Health Services Commission in the interests of a better health care system and with the objective of more quickly achieving health care reform goals.

I know that the minister, in our deliberations during presentations around this bill, wondered out loud if we were still supporting this bill. I can assure him that we are, but we have raised questions and have listened carefully to the concerns this afternoon. In fact, we are concerned that the focus of this minister and this government may be moving on rhetoric, as we have seen in the health care reform plan, and on moving boxes around as we have seen with respect to the reorganization of the department and, of course, Bill 75, which provides the legal basis for that reorganization.

We want to put on record time and time again that we hope there is more to the health care reform plan than the rhetoric of documents circulated and the reorganization of departments that we have been accustomed to seeing over the last number of years.

There are legitimate questions to be raised about the question of such a reorganization that puts enormous power in the hands of one individual, the Minister of Health. The MMA, in its written brief, although they were not able to be here for actual presentation, clearly raised that whole issue. I think it has to be taken seriously.

We have not changed our position as a result of that brief, but we think we have to be sensitive to the concerns raised and make sure we are vigilant in addressing them. As I have said in second reading and during Estimates, and this is a generic comment that does not reflect on one individual, power concentrated in the hands of a benevolent leader is one thing, but power concentrated in the hands of a tyrannical dictator is quite another thing. Of course, there are legitimate concerns to be raised when we reorganize a department and give such incredible power to the Minister of Health.

Let me also indicate that the minister is quite right and the Liberal member is quite right in referencing the fact that these discussions for amalgamation and reorganization have been underway for some time and were a part of the NDP agenda leading up to 1988. I want to indicate very clearly that in the



presentations and research done under that administration, there were clear plans and discussions to try to address some of the concerns we heard this afternoon around consumer health activist issues, around patient rights, around more participatory decision making.

I just want to put on record the regret that we do not see through this legislation a more substantive framework for a health board that would allow for the kind of representation the health care consumers this afternoon called for, that would allow for more of a significant role in terms of input around the government's health care reform agenda, that would allow for some innovative mechanisms to lead toward addressing long outstanding issues around facility governance and around advocacy and around patient rights and access to health care records.

The minister is muttering away from his seat as if this is a frivolous comment. I just want to say, Mr. Acting Chairperson, that the suggestions made this afternoon and what I am saying now are not frivolous comments. It is quite within the purview of this kind of legislation to put in place a more meaningful health care board. The MMA, in its brief, expresses concern about the fact that we will be without in government this arm's length body being able to criticize and being able to have input and a fresh independent perspective on decision making.

All I am suggesting, and I am not amending the bill—well, the minister should read the brief by the MMA—all I am suggesting is that I hope that the minister will use whatever means possible within this legislation and outside this legislation to address the concerns of the health care consumers, the likes of which we heard from this afternoon, and try to put in place a representative body that can give that kind of constructive, independent advice as we go through these difficult times ahead of us.

The minister knows we have raised concerns about the number of different advisory bodies. We are increasingly confused by this humongous outgrowth of bodies and we do not know who is making the decision. We raised that time and time again in the House. We raised it today again with respect to psychiatric care. We still do not know who is making decisions.

We think that if this legislation entrenched very seriously and carefully a health board that had that kind of broad representation and expertise, it could be a valuable vehicle within government for

achieving health care reform and achieve something that numerous critics outside of any political organizations, but from institutions and organizations much more closely associated with the minister who have said there has to be a consolidation of all of these studies and reviews and recommendations and I think the health board could have been a body to do just that if the framework had been set out in legislation.

Let me end by saying that we heard from a lot of people today who have been trying to reach the minister, who have been trying to at least have the opportunity to express their views. For reasons unknown to us, the minister has chosen not to meet with those individuals and organizations and at least hear their concerns. That is contributing to growing cynicism in our population about politicians and governments.

We all feel the effects of that cynicism, doubt and skepticism about politicians, and we are all interested in correcting that image. We just hope that the minister has heard the messages today and that he will, in good faith, meet with these organizations, at least hear them out and consider their very serious and important recommendations.

**Mr. Acting Chairperson (Mr. Rose):** Does the critic for the second opposition party have an opening statement?

**Mr. Gulzar Cheema (The Maples):** Mr. Acting Chairperson, as I said, this bill will simply reinforce what the three parties have been saying for so long, simply consolidating two departments and giving more accountability and in terms of giving a more clear-cut direction from the minister's office and being more responsible. Certainly, there are some concerns here from various organizations, but once you bring in bills, there are going to be some individuals who are opposing and some who are coming forward. Our aim is to make sure the people of Manitoba will get the best benefit.

I sincerely believe that this bill will help because the Minister of Health will be more accountable. I think that is a positive step.

**Mr. Orchard:** Mr. Acting Chairperson, I just want to indicate to my honourable friend, the member for St. Johns, I appreciate her sincere approach to the issue. I would ask my honourable friend just to give a small amount of consideration to a series of—I will give you a step by step.

Should someone with a problem with the health care system, after having consulted a multitude of physicians inside and outside of the province and met with many levels of staff within the ministry, including the ministry's office, political staff, including going to the Ombudsman, including going to almost every avenue of appeal that is available in today's system, all of which were available when my honourable friend governed, some not, most of them there—when the response does not satisfy the individual, is my honourable friend suggesting that we should create yet another forum? When the Ombudsman has looked, when individual after individual professional staff persons have tried to deal as best as possible with an individual's concerns and in highly charged and emotional matters, sometimes it is difficult to accept a professional or an administrative opinion.

\* (1820)

I just want to indicate to my honourable friend I did not wish to engage in debate with the individuals who were here this afternoon. I can assure my honourable friend that at least two of the four presenters this afternoon have had the most extensive liaison with government, the Ombudsman's office and almost an exhaustive list of consultation and were, for personal and strongly believed reasons, not satisfied with the answer. It was not because government, government officials and medical professionals did not try to deal with the issue.

Now, I guess I have to say to my honourable friend that when in opposition it is pretty easy to say there should be this form and this avenue when advocacy is presented at committee. I want to assure my honourable friend that some of this advocacy that we heard this afternoon was there in 1988 when I came into government and was there with the previous administration.

I get somewhat offended when the attack becomes personal that someone is not listening to them when we have exhausted almost every avenue there is. I assure my honourable friend that reasonable avenues are and will and continue to be pursued but, in some circumstances, the answer is unacceptable to the individual. I do not deny their right to advocate further, but to leave an impression that no consultation, no investigation by government and/or funded agencies has taken place, is inappropriate.

**Ms. Wasylycia-Lois:** Mr. Acting Chairperson, I certainly appreciate the remarks of the minister, and I just want to be clear about our position on the whole range of issues that were raised today.

I want the minister to recall that at no time did we attempt to question any of these individuals on their personal circumstances or their individual cases. In fact, I made a point of quite clearly saying I was not going to get into the medical issues. I wanted to go from the specific to the general as it applied to the whole movement happening around us and in this country around consumer involvement and advocacy and patient rights. It is not just happening in the grassroots community. We now have a Supreme Court decision that has ruled in terms of patients' access to information.

I was clear about staying away from the personal situations and not implying that the medical profession as a collective or any individual of that profession had done something wrong. I do not pretend to know all about the medical profession. I do not pretend to understand everything about how it works.

I want to be clear on the record today that I think what was important about all of the presentations was how we could learn something in a general sense from their individual cases. I think the most important part of this afternoon was hearing from the collective, from the group of them in terms of their general policy ideas and suggestions.

My only recommendation today and questions to the minister today were about meeting with groups and individuals who have come forward with policy ideas and suggestions for how we can improve the system. I want the minister to know that is where we intend on keeping the public debate and the use of this committee.

**The Acting Chairperson (Mr. Rose):** Thank you. Consideration of the Title and Preamble are postponed until the clauses have been considered.

Given the lateness of the hour, is it the committee's will to pass the clauses of Bill 75 in their entirety? Is that agreed?

Clauses 1 to 59 inclusive—pass; Schedule—pass; Preamble—pass; Title—pass. Bill be reported.

The time is now 6:25 p.m.. Is there anything more to come before this committee? I would like to thank the members of the committee for their patience and debate.

Committee rise.

**COMMITTEE ROSE AT: 6:26 p.m.**

**WRITTEN SUBMISSION PRESENTED  
BUT NOT READ**

Dear Mr. Orchard:

Re: Bill 75—The Health Services Insurance Amendment and Consequential Amendments Act

The main purpose of this legislation is to terminate the Manitoba Health Services Commission and transfer its jurisdiction and obligations to the Minister of Health, who becomes responsible for the administration and operation of the health services insurance plan. This concept had been considered by the previous NDP government and now has found favour with the current government. We also realize that several other provinces have amalgamated the administrative and political aspects of their publicly funded health insurance schemes.

The association laments the commission's demise because an important structure for public input and accountability will have been lost, an arm's length relationship between the administration of the province's health plan, and uncertain political agendas will no longer exist. We fear the consequence will be a lack of continuity in healthy policies as governments change, and no prospect for long-term planning, without which the system stumbles through uncertainty. This will make the rational delivery of health care more different than it already is.

Some people would argue that the commission's authority had so declined in recent years that its continued existence had become irrelevant. This may be so, but the association notes cumulative political interference led to this unfortunate result. In principle, the association thinks it is unwise to vest

any one individual minister with too much power, especially the power to control the delivery of health services to Manitobans. The potential for bad decisions that will harm patients is great indeed. It is no answer to say that the minister as an elected official will face his critics on election day. It will be too late for those persons affected by the minister's actions or inactions.

The establishment of a Manitoba health board to hear appeals from the minister's decisions in certain circumstances is not comforting. Any statutory process is slow, cumbersome and expensive. It is not an effective mechanism for the average citizen, patient or health care provider. Immediate public debate is always more effective in a democracy and the existence of a Manitoba health board will not promote timely public discussion.

The association realizes that Bill 75 will be enacted despite its concerns. Nonetheless, we want the public record to show that the province's physicians were not supportive of a greater concentration of power over vital health care matters.

Bill 75, incidentally, provides under S. 85(3) that the minister or the Medical Review Committee may disclose the name of a medical practitioner affected by an MRC order, the amount of repayment ordered, and the reasons for the order, while safeguarding patient confidentiality. This amendment is consistent with the association's recommendation made to you in a letter dated April 8, 1992, and we are pleased to offer our support for this particular change.

Sincerely,  
Scott Cleghorn, M.D.  
President, Manitoba Medical Association