



Legislative Assembly of Alberta

The 30th Legislature
First Session

Standing Committee
on
Private Bills and Private Members' Public Bills

Bill 205, Human Tissue and Organ Donation (Presumed Consent)
Amendment Act, 2019
Bill 207, Conscience Rights (Health Care Providers) Protection Act

Thursday, November 21, 2019
4:45 p.m.

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Standing Committee on Private Bills and Private Members' Public Bills

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Standing Committee on Private Bills and Private Members' Public Bills

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4:45 p.m.

Thursday, November 21, 2019

[Mr. Ellis in the chair]

The Chair: Thank you very much, ladies and gentlemen. Good afternoon. I'd like to call this meeting of the Standing Committee on Private Bills and Private Members' Public Bills to order and welcome everyone in attendance.

My name is Mike Ellis. I'm the MLA for Calgary-West and chair of the committee. I'd ask that members and those joining the committee at the table introduce themselves for the record. We'll begin to my right.

Mr. Schow: Joseph Schow, MLA, Cardston-Siksika.

Mr. Neudorf: Nathan Neudorf, MLA, Lethbridge-East.

Ms Glasgo: Michaela Glasgo, MLA, Brooks-Medicine Hat.

Mr. Sigurdson: R.J. Sigurdson, MLA, Highwood.

Mr. Horner: Nate Horner, MLA, Drumheller-Stettler.

Mr. Jeremy Nixon: Jeremy Nixon, Calgary-Klein.

Mr. Jones: Matt Jones, Calgary-South East.

Ms Sigurdson: Lori Sigurdson, Edmonton-Riverview.

Member Irwin: Janis Irwin, Edmonton-Highlands-Norwood.

Ms Pancholi: Good evening, everyone. Rakhi Pancholi, Edmonton-Whitemud.

Mr. Nielsen: Good evening, everyone. Chris Nielsen, MLA for Edmonton-Decore.

Dr. Massolin: Good evening. Philip Massolin, clerk of committees and research services.

Mr. Kulicki: Good afternoon. Michael Kulicki, committee clerk.

The Chair: All right. Thank you very much.

There are no official substitutions for the record. I think we'll just note that MLA Jones as a Member of the Legislative Assembly certainly is permitted to be at the table and ask questions; however, he is not a voting member of this committee and cannot make any motions.

A few housekeeping items to address before we turn to the business at hand. Please note that the microphones are operated by *Hansard*. Please set your cellphones and other devices to silent for the duration of the meeting. Committee proceedings are live streamed on the Internet and broadcast on Alberta Assembly TV. The audio- and video stream and transcripts of the meetings can be accessed via the Legislative Assembly website.

We'll next go to approval of the agenda. Are there any changes or additions to the draft agenda?

If not, would someone like to make a motion to approve the agenda?

Mr. Neudorf: I so move.

The Chair: Mr. Neudorf. Okay. Mr. Neudorf will move that the agenda for the November 21, 2019, meeting of the Standing Committee on Private Bills and Private Members' Public Bills be adopted as distributed. All in favour, say aye. Any opposed? That motion is carried.

All right. We'll next go to the approval of the minutes from the November 18, 2019, meeting. The minutes of the November 18, 2019, meeting are expected to be available for the committee to review at its next meeting, likely because the clerk has received a lot of submissions for the bills that we have before us right now, so he has certainly been quite busy.

Bill 205

Human Tissue and Organ Donation (Presumed Consent) Amendment Act, 2019

The Chair: We will move on to item 4, review of Bill 205, the Human Tissue and Organ Donation (Presumed Consent) Amendment Act, 2019, the stakeholder presentations. Hon. members, at our last meeting, on Monday, the committee agreed to invite stakeholders to provide oral presentations on Bill 205 and to accept written submissions with respect to this bill.

The caucuses were requested to submit their list of stakeholders to me by noon on Tuesday. For the record the opposition caucus requested to hear from the Alberta Transplant Institute and the Kidney Foundation, northern Alberta branch, while the government caucus requested to hear from the Alberta ORGANization Group, Dr. Tim Caulfield, Dr. Matthew-John Weiss. Dr. Caulfield and Dr. Weiss were unable to participate in today's meeting, but they provided written submissions, which are available on the internal website under Next Meeting Documents.

Joining us today are representatives from the Alberta ORGANization Group; the Kidney Foundation, the northern Alberta branch; and the Alberta Transplant Institute. I guess that first up we'll have the Alberta ORGANization Group. I'd like to invite Linda Powell and Dr. Greg Powell and Murray Wilson from the Alberta ORGANization Group to join us at the table to provide a five-minute presentation, followed by up to 15 minutes of questions from committee members. Thank you very much for joining us.

All right, folks. Thank you again for joining us. Whenever you are ready, the floor is yours.

Alberta ORGANization Group

Ms L. Powell: Thank you very much. Committee Chair Ellis, members of the standing committee, thank you for the opportunity to present to you today regarding Bill 205, and we would like to thank MLA Jones for bringing this bill forward. It is a very important issue. Our presubmitted material includes our full submission, an executive summary, and also provides the background on the Alberta ORGANization Group collaborative, which explains our strong desire to support increased organ donation and transplantation in Alberta.

Donation and transplantation are life-saving. We all know that at the same time there is a profound grief and devastating loss of a family member who has chosen or whose family has chosen to donate their organs.

Each of us within the collaborative has a connection to donation and transplantation in some way. This is also personal. We three here have lived this experience, with Murray a transplant recipient, Greg a once-listed transplant patient, and myself as a caregiver for Greg in this situation. Murray will also assist me with financial questions and Greg with the medical system questions.

The presentation of Bill 205 has again brought the importance of organ donation to public discussion. Building a strong donation culture is hard work to ensure there is no missed donor opportunity and to ensure that we honour end-of-life wishes and the right of every citizen to donate one's organs and tissues. This is a complex issue, as we all know, and we'd like to bring forward a few points.

Presumed consent is one and not a sole strategy to increase organ donation and is not a silver bullet. From the literature, it has not definitively demonstrated a causal increase in deceased organ donation rates but certainly by association with other existing strategies or concurrently implemented strategies. Presumed consent, if considered, we feel must be part of a comprehensive, well-developed and -resourced system to increase deceased organ donation and transplantation rates. Of course, the system we're talking about also includes living donation for kidney, lung, and liver patients although not being discussed today.

We are all watching the evolution of the Nova Scotia recently legislated presumed consent system. A multiple stakeholder research project has been in place to track their progress. The timeline for Alberta's Bill 205 provides the opportunity to watch that implementation and learn from their experience in the Canadian context and to develop a culture of consent in Alberta.

Key strategies and best donation practices would best be put in place first to form the foundation and infrastructure of a well-developed, -resourced donation and transplant program. These are, in order, one, mandatory referral of potential donors to the ODO, the organ donation organization. Of course, mandatory referral has been included in this bill and is an important component.

Two, continuous audit and timely feedback processes on donor identification, referral, and family consent rates. Family consent rates in Alberta are down now to 50 to 55 per cent. Ten years ago it was approximately 80 per cent. This audit, feedback, and reporting process is absolutely essential and a key element of a high-performing system in addition to and as an extension of the quarterly reporting process outlined in the bill.

Three, trained specialized organ donation teams and their initial and ongoing professional education, both rural and urban providers.

Four, public awareness, engagement, and education, which cannot be overemphasized when considering presumed consent. The need for family understanding and family member consent remains the same whether in a soft opt-out or an opt-in system. The families must have that kitchen table conversation about what they wish for their end of life.

Five, a user-friendly donor registry and, six, co-ordinated organ retrieval and transplant facility resources.

We believe that an overarching, accountable, well-defined governance structure, with regular reporting to the minister as outlined in the bill, is essential. Based upon our financial and economic analytics, carried out by AOG, we also believe that there are very compelling budgetary and macroeconomic benefits from a well co-ordinated and appropriately resourced donation and transplant program and system.

The current act includes provisions for an accountable agency structure, public awareness, professional education . . .

The Chair: Thank you very much. I certainly hesitate to interrupt, but the five minutes have expired. We're certainly under very strict timelines when it comes to this particular committee.

We will now open the floor to up to 15 minutes' worth of questions, as has been the standard practice with this committee. As this is a government member's bill, we will start with the Official Opposition. I see Mr. Nielsen. Go ahead.

Mr. Nielsen: Thank you, Mr. Chair. I want to thank you for coming to present this evening. As usual, we tend to ask a question and maybe a follow-up. Maybe for my first question, if you wouldn't mind finishing your thoughts just before the buzzer went off.

4:55

Ms L. Powell: I can.

We recommend that these actions be taken and/or continue to be implemented and that full-time leadership and authority of an organizational organ donation and transplant framework be put in place. Presumed consent can be an added opportunity and strategy with the implementation of significant community education, engagement, and support. This can be the catalyst. This bill can be the catalyst for change in Alberta.

Thank you.

Mr. Nielsen: Great. I guess for my follow-up question, then, Mr. Chair, I noticed that during your comments you said that basically it's hard work to build that donor list. I think that as legislators sometimes we can get caught up in the legislation we write. You know, we come up with some great language, but then that's it. We've got great language but nothing else to move it forward. I was wondering if you might want to maybe provide some comments around: how important is the infrastructure that needs to be in place? I mean, it's great that we grow a donor list and have these donors ready to go, but if we're not able to capture those donations, would all of this be for nothing?

Ms L. Powell: All of these pieces fit together in a matrix, and they're all important. It's a bit like building a house: you need a solid foundation and all of the rooms in the house have to connect to have an effective living space. Presumed consent is one part of that. But as we mentioned in the presentation, there are so many different components. There are different pieces happening, but they need to be brought together under one structure, and presumed consent is part of that culture of donation and consent that needs to be part of that framework and foundation.

Mr. Nielsen: Thank you very much. I appreciate it.

The Chair: Thank you very much.

Mr. Schow, go ahead.

Mr. Schow: Thank you, Mr. Chair, and thank you, Ms Powell. I have a question. Something that you addressed early on in your statements regarding: presumed consent is not really the silver bullet here; it's part of a much larger approach. Can you maybe expand on: what would be the appropriate first step in that? Is this bill that first step, or is it something else that you may recommend as being added to or removed?

Ms L. Powell: Well, certainly, the mandatory referral and the audit processes that were mentioned are very, very important. Of course, the mandatory referral consideration is in the bill. Currently the legislation states that it's mandatory consideration. Mandatory referral takes it that extra step.

The quarterly reporting to the minister is a very important next step, but also with that are the ongoing, continuous audit processes that need to be in place. So donor identification by physicians and then the referral to an agency and then the follow-up with the family – the donor co-ordinator would start working with the family – all of those pieces need to be strengthened and well in place. The audit process allows us to track consent rates, see how many donors might have been missed. We never want to miss donor opportunity, and the audit process allows us to identify that. Certainly, Canadian Blood Services has outlined that those two pieces are very important in developing a system.

The Chair: And you have a supplemental?

Mr. Schow: Yeah, just a quick follow-up. I'm not overly familiar with the donor process, so you'll have to forgive me. Can you

maybe talk a little more about it? You're saying that you might be missing donor opportunities without the auditing process. Are we currently missing a lot of donor opportunities, in your opinion?

Ms L. Powell: We are, and there's significant literature to identify that, as has been outlined in some of the material that we forwarded.

I'd like to ask Dr. Powell to comment on that from a physician perspective.

Dr. G. Powell: Thanks, Linda. We live in a complex world with a complex medical system and a layer of complexity and ethical space in the donation world, so that complexity needs to be addressed with a cultural change as much as anything, and that will happen. I think the two-year time frame put in this bill will be incredibly helpful to sustain that.

The Chair: Thank you very much.

Member Sigurdson, go ahead.

Ms Sigurdson: Yes. Thank you. Thank you so much for your presentation. I just wanted to look a little bit at, besides the presumed consent, the other pieces. Like, you talked about having a more comprehensive plan. Certainly, in some of the submissions that we received regarding this, actually one from Dr. Jackie Sieppert, another from Dr. Jake Kuiken – these are social work colleagues of mine, actually, that I know – they talked about their personal stories and some of the challenges, obviously. Dr. Sieppert's son passed away before he could have a kidney transplant, and of course Dr. Kuiken's wife continues to have many challenges.

What they both talked about, though, is something that you talked about – and I think Dr. Caulfield talked about it, too, so it seems to be a theme – that, yes, presumed consent does take us part of the way there. But without public education, without public awareness – you talked about professional teams, rural and urban – without these kinds of supports around it, it's insufficient. I just wondered if you could expand a little bit on any of that.

Ms L. Powell: Well, certainly, the literature has demonstrated that there's a varying increase in donation rates with presumed consent, but in every case the presumed consent was put in place with other supports to make sure that the system operated well. Each one of us as an individual citizen needs to have that conversation with our families about what we want our end-of-life wishes to be, but it doesn't stop there. Then when the situation does occur where we're faced with that terrible situation, we want to make sure that all of those organizational pieces are in place to help it happen appropriately and quickly and meet our loved ones' wishes. It needs to be resourced – that's really important – and certainly all of the pieces need to be brought together under one organizational structure.

Many jurisdictions have an organ donation and transplant system together. We have a very strong group of professionals in our province; we're very, very fortunate. We're hoping to give them more tools to be able to do their job.

Ms Sigurdson: Great. Just one supplemental if I could: can you point to a jurisdiction that you feel is doing what you're wanting us here to do in Alberta besides the presumed consent, having that, you know, public awareness, education, professional teams? Is there a jurisdiction that you can point to that you feel is along the way?

Ms L. Powell: We don't have to look very far. B.C., Ontario, Quebec, Philadelphia, Kansas, Croatia, Spain, Wales, England are some of the jurisdictions.

Ms Sigurdson: Okay. Thank you.

The Chair: All right. Mr. Horner, go ahead, please.

Mr. Horner: Thank you, Mr. Chair. Through you to Ms Powell and to you, gentlemen: thank you for being here today. I was just thinking about what MLA Sigurdson said about the infrastructure in rural and urban to support a program like this. I have a friend and constituent who unfortunately lost a son just two weeks ago, and it made me think about the very special scenarios where this is only applicable. You know, in this case he was on ventilation; he was already moved to the Stollery. It then gave the family time to have that conversation. I think the conversation is always going to be the biggest part of making sure something like this is successful.

Thinking about rural infrastructure and your background with STARS, do you think that might be one of the tools to beef up the infrastructure to make this program work stronger, that flexible, quick recovery of patients? Is that a direction we need to look for rural Alberta to participate in this?

Ms L. Powell: I'll make one comment and then ask Dr. Powell as founder of STARS to comment. Certainly, the transportation of patients, individuals who may be donors, and organs and tissues is really important. It's one piece of it.

I'll pass it to Dr. Powell to comment further.

Dr. G. Powell: Sure. Going back to a previous question about donors being missed, donor identification is a complex issue, and it's not something that every physician carries, particularly in rural settings. In our advanced ICUs, of course, that's a little different. But time and talent mixed together are what makes the difference. If we can get people, whether it be ground, air, or other methods of transport, at the right time, we can make a difference in, obviously, saving their lives and, if we can't save their lives in a prolonged way, at least looking at the possibility of organ donation. Yes, I think that's very important, that we consider transport medicine as part of this.

The Chair: Thank you.

Go ahead. A supplemental? Oh, you've already done it?

Mr. Horner: I'll cede my time.

The Chair: Thank you very much.

I think we have Mr. Nielsen next. Go ahead, sir.

Mr. Nielsen: Thank you, Mr. Chair. I was hoping to be able to tap into this knowledge of the different areas and whatnot. Do you have any insights into maybe jurisdictions or even insights you already know about in how we can approach our indigenous communities around the subject of organ donation? You know, how can we proceed in a meaningful way where they feel included within these discussions to move this legislation forward?

5:05

Ms L. Powell: That's a good question. Certainly, the Alberta ORGANization Group approached this topic from an analytical, economic, and financial perspective originally. In fact, presumed consent was the first foray into this conversation, and then we looked at ways that possibly we could help advance organ donation and also if it's a cost-effective conversation. Different populations may utilize organ donation greater than other populations, and certainly engagement would need to occur. We have not been part of that. There may be other stakeholders who could comment more closely on that.

Mr. Nielsen: Great. Thank you very much.

The Chair: Are you good, sir? Thank you very much.

Mr. Sigurdson, try to be brief.

Mr. Sigurdson: Yeah. I mean, I was just referring back to a couple of your comments. You had made comments about how this bill brings out mandatory referral, quarterly reporting, an audit process, and kind of those steps and how they impact. I guess I just want your opinion, a little bit of a touch on your position on opt-out over opt-in and what that sends as a message and what you think the benefits are to that, like, just in that scope itself, just that statement. What does it make?

Ms L. Powell: That's a key question. Most jurisdictions have the opt-in scenario, and a number of jurisdictions have started adopting the opt-out in order to try to increase their organ donation but with other resources put in place. If it's well done – and this is what other jurisdictions seem to indicate in their literature – with good education and public engagement, good communication tools, and a sense of where the public would like to go with it, it can be a successful scenario.

Mr. Sigurdson: Excellent. Do you think that by the government doing this, it does send a clear message, though, that it is important and that we're trying to direct people to this, to have the conversation?

Ms L. Powell: I think this conversation about organ donation and transplant is really important and is sending a message to the public that we need to honour all of our individual rights and wishes for end of life, which include organ and tissue donation, and it brings the conversation to the front mind, that we should all have this conversation with our families. No matter whether it's presumed consent or opt-in, we need to have the individual conversations with our families so that everyone is aware of what our wishes are. That doesn't change with presumed consent. We should have those conversations so when the very difficult time comes to confirm those decisions, everyone is on the same page.

The Chair: Member Pancholi, you've got about a minute and a half.

Ms Pancholi: Actually, that leads very well into my question. Thank you very much for being here, for presenting. I want to talk a little bit more about something that MLA Jones, when he brought forward this bill, mentioned when he was presenting it, which is that the presumed consent does not change that the next of kin or the family ultimately makes the decision – right? – at the time. We know that that's difficult.

Often when we think about public education around organ donation, we're talking about educating people to make their decision to opt in or opt out, as the case may be, but to actually make the decision to donate. But I'm wondering about focusing on that point in time when it's actually the family who in both cases, presumed consent or not, ultimately does get to make the call, sometimes regardless of whether or not the deceased person has actually expressed their wishes. How do we increase the education for families at a critical time – right? – and, we know, a difficult time to actually support them in making those decisions so it's not just about the person donating but also about, you know, the families making a decision to respect their wishes? How do we focus on that kind of education? Your thoughts on that, I should say.

Ms L. Powell: I think that what we're talking about is creating a culture of donation, and from that is the culture of no missed donor opportunity. The culture of donation requires, whether it's in school, whether it's a doctor's office, whether it's in the supermarket, that this is an accepted norm, that we talk about this. Increasingly, we are talking about end-of-life issues, and this is one of them.

The Chair: Thank you so much. I appreciate that. I apologize. The allotted time has expired for this part of the program.

I'd like to once again thank the representatives from the Alberta ORGANization Group for presenting here today. Thank you so much for being here.

We will next move on to the Kidney Foundation, northern Alberta branch. If you folks could start making your way to the table, please.

Committee members, ladies and gentlemen, I'd like to invite Flavia Robles de la Fuente and Manuel Escoto from the Kidney Foundation to join us at the table to provide their five-minute presentation, followed again by up to 15 minutes of questions. I see them seated; that's fantastic. Whenever you are ready. Thank you.

Kidney Foundation of Canada, Northern Alberta and the Territories Branch

Ms Robles de la Fuente: Thank you, Chair and committee members, for inviting the Kidney Foundation today and providing us the opportunity to provide input on Bill 205. Thank you to MLA Matt Jones for bringing the issue of organ donation to the Legislature and recognizing that this is a starting point. It's been five years since legislation on organ and tissue donation was passed.

Organ transplantation is the most clinically cost-effective treatment for organ failure. For Albertans waiting on a transplant list or ineligible for a transplant, their health journey is often lengthy, costly, and impacts their physical, emotional, mental, and financial state. Organ donation allows patients to live with few restrictions as they can travel, have more time for family and friends, return to school, be involved in their communities, and lead a normal life.

Despite end-stage organ failure being a treatable disease, Alberta's organ donation and transplant rates lag national and international levels. As of December 31, 2018, despite 382 life-saving transplants performed in Alberta, 654 Albertans remain on the transplant list, and there are thousands of others that are currently not on the list. Given these statistics we need an improved organ donation system. As a result, the Kidney Foundation of Canada supports initiatives that implement system best practices and build a culture of donation in Alberta so that there are no missed donor opportunities.

On Monday both Mr. Jones and Alberta Health correctly outlined that only 1 to 2 per cent of deaths occur in a situation where there is an opportunity for a donation to take place. The goal of an improved organ donation system should be to ensure that there are no missed donor opportunities among this 1 to 2 per cent of individuals, especially those who have indicated their intentions to be an organ donor.

In regard to presumed consent the Kidney Foundation of Canada supports opt-out consent when it is part of a comprehensive strategy to improve organ donation and transplantation systems in Canada. A successful system would include implementation and monitoring of best medical practices, public and professional education, and the development and co-ordination of an advanced interprovincial organ-sharing and data-monitoring system.

With respect to Bill 205, the literature is not conclusive on the value of opt-out as a leading strategy. Spain introduced the opt-out system in 1979 and didn't see an increase in transplant rates for over a decade, and then it was only due to the introduction of policy

measures that overhauled its organ donation system. Today the policy measures implemented in the Spanish model are recognized global best practices. As such, we support system best practices. The implementation leads to better performance and an overarching goal system for best practices to ensure, again, that there are no missed donor opportunities.

First, mandatory referral. We are in full support of this change, that replaces mandatory consideration.

Second, continuous real-time donor audits. Real-time donor audits allow the system to identify challenges, successes, and opportunities to organ donation by reviewing how a potential organ donor's circumstances were handled. The current bill has stated quarterly reporting to the minister, which again we support, but we recommend that real-time donor audits are provided to the organ procurement teams as well.

Third, highly trained donation teams. These teams would be specialized in donor identification, donor referral, and a donor management system that would be implemented in rural and urban ICU centres. Hospital donation physicians promote a culture of donation inside their hospital and provide educational support and shared expertise to the hospital staff. Their role is to help ensure that no family misses the opportunity to create a life-saving legacy for a loved one by choosing donation. In other countries, donation systems that included these changes in hospital specialists have resulted in increased deceased organ donation rates.

Fourth, an improvement of public awareness regarding the need and benefit of organ donation. We need to ensure that public education and awareness are prevalent and ongoing so that Albertans are able to register an informed choice.

5:15

Lastly, ensure Alberta's donor registration process is user friendly.

In conclusion, we are thankful that Bill 205 has opened up the conversation amongst government and the public, but let's also learn from what has worked in other jurisdictions. We thank MLA Jones for recognizing the burden that organ failure has on patients and communities across Alberta. We recognize it is a private member's bill, so everything we recommended may not be able to be included. We support a comprehensive strategy to improve organ donation, as outlined by the five policy initiatives stated, and urge committee members . . .

The Chair: Thank you very much. I hesitate to interrupt. The time allotted has expired.

We will now move to 15 minutes' worth of questions. We will start with the Official Opposition. I see Mr. Nielsen. Go ahead, sir.

Mr. Nielsen: Thank you, Mr. Chair. I didn't actually have this in my notes, so it's kind of just off the top of my head, but maybe I will use my first question to ask if maybe you could just quickly finish your thoughts.

Ms Robles de la Fuente: Thank you. I was so close.

We support a comprehensive strategy to improve organ donation, as outlined by the five policy initiatives stated, and urge committee members to take the recommendations back to government. We know that transplantation saves lives and saves money, and it's a win-win for the province.

Thank you.

Mr. Nielsen: Thank you.

For my follow-up, Mr. Chair, in the document that I've just received here, it looks like Spain seems to be the model that we can all aspire to. What are some of the things that you think Alberta would need to do in order to duplicate some of that success so that,

like I said, we're not, you know, taking this private member's bill, passing it through, but then nothing else really happens with it? We want to make sure that it succeeds.

Ms Robles de la Fuente: What's really great is that today and perhaps before you've heard some synergy already. It really does mean a comprehensive system, the mandatory referral to be able to have that ongoing donor audit. We need to identify the opportunities, challenges, any loopholes that were perhaps missed that can help facilitate a donation. Extremely important. When we mention public education and awareness, it is so important. We value an individual's decision to be able to pursue organ donation as an informed choice. That leads to talking to their family, but before they can even talk to their family, they have to understand what that means. That is a very important component to help make the registration process a little bit, you know, easier for everyone to be able to facilitate.

With all of that and the donor teams that are in every single ICU in the hospital, with all of those working together – and you have seen and you've heard from not just the other provinces here in Canada but from the Spanish model and Croatia, that increased to significant levels their deceased organ donation rates, and I know that in Alberta we can absolutely do it, too.

The Chair: Thank you.

Member Glasgo.

Ms Glasgo: Thank you, Mr. Chair, and thank you so much for your presentation. I think we've heard now twice about this culture of donation. I was just wondering if you could expand on what this really means to you and the Kidney Foundation.

Ms Robles de la Fuente: For us, it means that there are no missed donor opportunities. You're hearing this; it's a theme. If we know that 90 per cent of Canadians believe in organ donation yet currently 20 to 23 per cent have actually registered their, you know, intent to donate, we have a disconnect. For us, it's about saving lives. Too many people and Albertans are needlessly dying. For the kidneys themselves, we have over 2,600 Albertans, and all of them should be able to receive a life-saving gift and be able to be contributing citizens. For us, it's about impacting lives. Really, with organ donation, I must say that there are very few things that you can say truly are a win-win, and that is what organ donation stands for.

The Chair: A follow-up? Go ahead.

Ms Glasgo: Yeah. As legislators we always talk about things like unintended consequences or potential negativities, but this bill seems pretty well rounded to me. I was just wondering if, from your perspective, you could enlighten us a little bit on anything that you see as a hurdle to this bill or basically on what you'd like to see go further or on how you're feeling about the outcome of this so far.

Ms Robles de la Fuente: For us, we'd like to be able to actually see that the mandatory referral move forward. We'd also like to be able to have the donor teams in every single ICU. It really does provide that donor audit continuously so that we're able to look at that.

In relation to the other elements that we've mentioned, I think they all fall in place. Everything that has been discussed all makes sense, and they're all going to contribute to that success that you're looking for.

The Chair: Thank you very much.

The Official Opposition. Go ahead, Member.

Ms Pancholi: Yeah. I just wanted to express my support, mostly because I've actually been to a number of the kidney walks myself.

In fact, Manuel, I recognize your name from the e-mails that I get encouraging me to sign up once again. I just think it's really important that we are hearing some consistency here with respect to the culture and the supports that need to happen.

We do know that this is a private member's bill, so there are limitations on what it can prescribe for government, specifically around funding and resources and money. But I do note that the sponsor has indicated that there would be a two-year delay before the full implementation of the bill. What would you say would be the primary focus, knowing that there are a lot of things? I hear very clearly that there are a lot of puzzle pieces that need to come together. What would you say, if this bill is passed, would be the first focus for implementation?

Ms Robles de la Fuente: I would say: that the mandatory referrals absolutely move forward. You know, I should have actually invited my colleague with the Alberta ORGANization Group, Murray Wilson, to join us because, again, on the cost-effectiveness of organ donation, you are able to achieve all of the things that we've been recommending, all five, and have tremendous cost savings. I refer back to what has been presented to you by the Alberta ORGANization Group, which actually shows the tremendous cost savings and that you won't have to pick one, because all of them merge together to be able to achieve the result that is needed for moving organ donation forward in this province.

Mr. Escoto: Can I add something? The other piece as well that I would certainly emphasize is the education piece. When we say "building this culture of donation," if the first point of contact is at the hospital when a loved one has passed away and if that's the first time that they're hearing about organ donation, there's a big disconnect there. We know that 90 per cent believe in organ donation. Throughout communities, throughout government everybody should be thinking about organ donation, and that's where education comes in. You have to have a comprehensive strategy. So when I heard that MLA Jones had proposed a two-year delay and that he'd focus on education, I mean, that's certainly a critical, critical piece that can start right away.

Ms Pancholi: Great. Thank you.
No follow-up. I'm fine.

The Chair: Thank you very much.
Mr. Schow.

Mr. Schow: Thank you, Mr. Chair, and thank you both for your presentations. In listening to your presentation, you talked about a couple of the steps towards getting to where we want to be; specifically, mandatory referrals and continuous donor audits. But I wanted to focus on the highly trained donation teams. I'm curious to know if there are currently, that you know of, any procedural or training shortcomings that we are suffering from that are resulting in some of these missed donation opportunities. Just to give you some context for this, I know that there is a very small percentage of people who are even eligible donors. I think Mr. Jones said that it was somewhere around 2 per cent. Just in trying to make sure that we are maximizing that 2 per cent potential, are there shortcomings that we know of right now through training or procedures?

Ms Robles de la Fuente: As mentioned earlier, we have tremendous knowledge here in Alberta, again, both in the north and the south. With education for the organ donation teams, a leading example would be Croatia and Spain, if we go to that. They're able to have them primarily appointed in every single hospital to be able to have the co-ordination, the knowledge, and the education to spread

throughout all the levels of donation. For instance, you can't have the same team that's actually working to save someone's life then turn around and say: "By the way, we did everything we could. Can we please have their organs?" Taking that aside, you have those that are trained, that are sensitive when it is a time of donation, and that additional training will lead to improved processes and organ donation management.

Mr. Schow: Okay. Just as a follow-up, you know, I don't speak for everyone on this committee by any stretch, but I certainly believe in organ donation. If something was, tragically, to happen to me and I could be one, I would be right within that group. But I'd also want to make sure that we get this right. Are you aware of any percentage numbers of those potential organ donations that are unsuccessful as a result of maybe some training shortfalls?

5:25

Ms Robles de la Fuente: What we know is that only 1 to 2 per cent are eligible, and I do not know the percentage of – yeah, we don't have that to know out of that 1 and 2 per cent. We're already looking at a very small number of how many actually pass through.

Mr. Schow: Right. Thank you.

The Chair: Good. Thank you.
The Official Opposition. Yes, Mr. Nielsen. Go ahead.

Mr. Nielsen: Thank you, Mr. Chair. I guess that maybe I'll ask the same question I did of our previous presenters around our indigenous peoples, about how we could connect with them in a meaningful way to be able to have these kinds of conversations.

Ms Robles de la Fuente: Absolutely. Along with indigenous as well as the diverse religious groups that have their own, you know, opinion, we absolutely support a person's right to make an informed decision. Specifically on indigenous, we cannot speak directly to all the issues that are faced by the community. However, we can say that indigenous communities are at a much higher risk of kidney failure and are at risk of experiencing a faster rate of kidney function decline at a younger age. In fact, across Canada it's three times higher to have your kidneys fail compared to nonindigenous people. What we have done as a foundation is go into the communities directly, with their invitation as we work in partnership, to be able to screen and have potential preventative measures, the awareness built. If we have the system itself doing the changes, then indigenous peoples are able to make that informed decision knowing that they're at a higher risk.

Mr. Nielsen: Thank you.

The Chair: Thank you very much.

Mr. Sigurdson: I just want to first start by saying thank you so much for everything you do. It's more than apparent, your compassion and care and love for what you're doing with the Kidney Foundation. Of course, my father, who recently passed, suffered from kidney failure, so he was ineligible as a donor, but this is something kind of near and dear to me. It's great to see in a bill some things that are lining up, from both of our presenters, that have an impact, the reporting as well as the mandatory referral.

I kind of wanted to touch a little bit on what my colleague had mentioned about the 1 to 2 per cent and the fact of, you know, missed opportunities. You talked about missed opportunities. I understand that you may not have the statistics on how many are

missed, but just in your opinion, will this bill help with reducing the missed opportunities?

Ms Robles de la Fuente: Absolutely. The more that we have everyone getting behind organ donation, understanding the importance – it is a fact that organ donation saves lives and it highly improves lives, so then they can be contributing members to community, society, et cetera. When we are trying to build a cohesive system, it's going to make those impacts across the board to everyone. We want from youth to teens: it should be part of a table conversation.

We keep talking about, specifically, kidney disease living in the shadows. Organ donation somewhat has lived in the shadows as well, yet it's come out, and whenever it does, people get behind it because they know the impacts it's going to make. A hundred per cent we want to make sure that if there was an opportunity for a donor to have saved lives – specifically, for organ donation, one person can impact eight lives, and if they're an organ and tissue donor, they impact up to 80 lives. How is that not a win-win for absolutely everybody?

Mr. Sigurdson: Excellent. Thank you.

Just one simple follow-up. You mentioned a slight differential here that I want to touch on, just on the quarterly reporting to real-time reporting. Do you know of other jurisdictions that do real-time reporting?

Ms Robles de la Fuente: Yes. Spain and Croatia do that, and Ontario is doing that. I'm actually not sure about B.C., but I'd refer it to my colleagues, who would pass along that information, absolutely.

Mr. Sigurdson: Excellent. Thank you.

The Chair: Thank you very much.

We'll now go to the Official Opposition. No?
How about back to the government members?

Mr. Jeremy Nixon: I'm wondering if you can comment on the problem of organ trafficking and as well if you can comment a little bit on the difficulty between choosing when you have a limited supply.

Ms Robles de la Fuente: Actually, for us, the goal of increased organ donation is to reduce that supply. The reason why so many Albertans are needlessly dying is because there is not enough supply. So if we can increase organ donation.

One of the things I also mentioned was that when we talk about those waiting, those 654 Albertans currently waiting, when you're not well enough to be on that waiting list, you're not on that list, but there's nowhere that they are actually counted. That's why we know that there are thousands more.

In relation to trafficking, well, we're against that. You know, there's no buying or selling of organs. We know that an informed public will be able to rise up and make organ donation a priority.

Mr. Jeremy Nixon: Thank you very much.

The Chair: Do you have a follow-up, sir?

Mr. Jeremy Nixon: No. I'm good.

The Chair: No? Okay.

Does any other member have a question? We're just under 30 seconds left. No? Okay.

You know what? Thank you very much to the folks from, obviously, the Kidney Foundation, northern Alberta branch. On behalf of all committee members here thank you so much for your presentation today.

If I could get the Alberta Transplant Institute to start making their way to the table. At this time, committee members, ladies and gentlemen, I'd like to now invite Dr. Norman Kneteman from the Alberta Transplant Institute to join us at the table to provide a five-minute presentation, followed again by up to 15 minutes of questions. Thank you very much. Doctor, when you are ready, you may begin.

Alberta Transplant Institute

Dr. Kneteman: Thank you so much. I'd like to open by thanking the committee for the opportunity to speak to the topic of organ donation and transplantation and specifically to Bill 205, Human Tissue and Organ Donation (Presumed Consent) Amendment Act, 2019. As you've heard, my name is Norman Kneteman, and I'm a liver transplant surgeon at the University of Alberta hospital in Edmonton. I'm also the chief of transplant for Alberta Health Services in the Edmonton zone, and I work with the Canadian Blood Services organization on organ and tissue donation as well as the organ donation and transplant collaborative with Health Canada.

Now, in my administrative positions but especially in my role as a transplant surgeon, one of the most important jobs I have is to advocate for, as you've heard, the hundreds of people on the waiting lists across our province and across our country. Although the transplant programs at the University of Alberta hospital will carry out over 350 transplants this year, and with an additional 75 or so in Calgary we have well over 425 transplants, we still at the end of each year have hundreds of people on the wait-list, and that's part of the basically over 4,000 people waiting for transplants across Canada. Tragically, 250 to 300 of those, as we understand, die each year waiting.

Now, efforts to improve this condition have been ongoing. Certainly, as witness to this work over the last 10 years, the rates of donation in fact in Alberta – some good news – have gone up about 50 per cent. Unfortunately, despite moving that donation rate to about 16 donors per million population in Alberta, we still find ourselves lagging behind the rest of the country, where the average rates are now up to 21 and above. There's a lot of work to do.

Now, there has been a lot of work and study in recent years that has gone into the understanding of characteristics of what we would call a high-functioning donation and transplant system. These leading practices are now fairly well recognized both nationally and internationally. They include several key components. I'd like to just run down through some of those for you.

One of them, and a key one, is mandatory referral of all potential organ donors to the responsible organ donation agency; secondly, the presence and training of appropriate numbers of donation specialists, donation physicians, health care professionals, basically, that are dedicated to supporting organ donation in hospitals. Implementation of programs in new areas such as donation after cardiac death are important, and in addition, basically, a dedicated agency or organization that's charged with the responsibility for leading organ and tissue donation, it's adequately funded to carry out these activities, and it's accountable and audited for this performance.

Unfortunately, Alberta still lacks several of these basic building blocks of a high-functioning donation and transplant system. In November 2013 the government of Alberta passed Bill 207, the Human Tissue and Organ Donation Amendment Act, 2013, which

was a bill to establish first an online donation registry and secondly a provincial co-ordinating agency for organ and tissue donation and procurement. Such an agency should develop, organize, and deliver the best donation and transplant access and outcomes for the people of Alberta. While the donor registry was established, the remaining components of the donation agency have unfortunately languished for several years without major progress in Alberta.

Bill 205 will certainly address one of these critical components of a high-functioning donation system, that of mandatory referral, and has the opportunity to provide significant support to our donation and transplantation activities overall through the institution of presumed consent. By establishing the mandatory referral of potential donors to organ procurement organizations within Alberta, Bill 205 should help to avoid one of the important faults in our current donation system by reducing the potential for failure to identify organ donors and also by being sure that we provide the opportunity for the donor or their families to control decisions about donating organs and tissues for transplantation.

5:35

The second important proposed change, that of presumed consent, is a significant change to our approach in this area. It is one that has a long history, in fact, in Europe, where it has been part of the plan and the system in Austria, Spain, and Belgium, countries that have long been leaders in donation and transplantation. This practice is continuing to gain support, as is witnessed by current work to implement presumed consent in the United Kingdom and also in Canada within the provinces of Nova Scotia and, most recently, Quebec.

As such, Alberta is perhaps on the vanguard of an ongoing movement internationally to recognize the broad support for organ donation and transplantation that exists throughout the Canadian population and that of much of the developed world. Presumed consent addresses the reality that over many years public opinion surveys have consistently shown rates of support above 80 per cent for donation and transplantation. Despite this public support we fail to achieve this outcome, and well under 50 per cent of the growing . . .

The Chair: Sir, I hesitate to interrupt. I certainly do apologize.

I will look at Mr. Nielsen and go to the Official Opposition. Mr. Nielsen, go ahead.

Mr. Nielsen: Thank you, Mr. Chair. Are you looking at my notes?

The Chair: No, but I could ask him to finish.

Mr. Nielsen: I was wondering if you wouldn't mind concluding your comments for us, please.

Dr. Kneteman: I would be happy to. The bottom line is that we have a real opportunity with these changes to improve three things.

First of all, these changes have the opportunity to save lives. People with kidney transplants have about twice the survival of those on dialysis. They also have a fairly dramatic improvement in their quality of life, and especially with kidney transplantation the cost of transplantation is basically significantly lower than dialysis. Each transplant that we do, we estimate saves probably \$300,000 to \$400,000 of dialysis costs over the life of that kidney. It's really a fairly unusual opportunity to win in three different ways: better survival of our patients, much better outcomes in terms of quality of life, and, in fact, with significant savings also, potentially.

Thank you so much.

Mr. Nielsen: I noticed in your comments right near the beginning that you had given some stats sort of basically between Edmonton

and Calgary. I noticed that Calgary was a little bit lower. Why is that?

Dr. Kneteman: You're referring to basically the numbers of transplants carried out?

Mr. Nielsen: Yeah.

Dr. Kneteman: The way that transplant services are delivered in the province of Alberta is basically split so that both Edmonton and Calgary have programs that perform kidney transplants and have had for many decades. In Calgary, basically, they have a very large and well-established program for bone marrow transplantation whereas Edmonton has always had the centre for solid organ transplantation: heart, lung, liver, pancreas. The numbers that I was referring to were solid organ transplants. The bone marrow program in Calgary actually does over 200 bone marrow transplants a year as well, a little bit of a different issue in terms of donation when we're talking about this.

Mr. Nielsen: Interesting. Great. Thank you.

The Chair: Thank you very much.

Mr. Horner, go ahead, please, sir.

Mr. Horner: Thank you, Chair. Thank you for being here, sir. It's interesting to hear some of the actual numbers on the transplants; I think you said about 350 in Edmonton and 75 in Calgary. We just heard from the Kidney Foundation that there are 4,300 Canadians on a list, 3,300 for kidney transplants alone. If we do this right and you have the capacity to perform these transplants, will we see an influx of Canadians coming to Alberta in hopes of shortening the wait time to a successful transplant?

Dr. Kneteman: Well, that would be a tremendous success if we could achieve that, but right now we're actually working hard to catch up to the rest of Canada.

Mr. Horner: Sure.

Dr. Kneteman: I mean, there is, obviously, portability of the Canada Health Act, but most people tend to stay in their home province, basically, if at all possible, because the family support and the systems that are behind people are an important part of this care as well. Going to another city across the country is a fairly daunting proposal for most people.

Mr. Horner: A follow-up, if I could, Chair?

The Chair: Yeah. Go ahead, sir.

Mr. Horner: The actual capacity to perform the transplant itself: will that be an issue immediately if this is successful?

Dr. Kneteman: If you had a huge change overnight, certainly, you'd need to have people to be able to actually carry out the work. I would suspect that in a situation like this even if we started to work hard on implementing changes and building things – for example, in Ontario, donor rates have improved about 50 per cent over the last several years. They have kept up, but they've certainly had to ramp up their transplant activities to do that. That's certainly, in my mind, I think a tremendous win if we can accomplish that. As I said, realistically, we would hope that we would save more money on dialysis, in fact, than we would probably spend doing the transplants.

Mr. Horner: Definitely. Thank you very much.

The Chair: Member Irwin, go ahead, please.

Member Irwin: Thank you, Chair. Thank you, Doctor, for your work and for being here. You noted that you work in conjunction with Canadian Blood Services, and I'm just sort of curious about some of the barriers around donation. Right now we know that active gay men and trans folks are not eligible for organ or tissue donation unless it's exceptional circumstances. I worry that some folks could be rejected from donating, you know, and there's no reason other than, really, stigma. It's a section of the population that's being discriminated against, and I think it points to the need for more education as well. I'm just curious: like, how do you work to overcome barriers like these?

Dr. Kneteman: Well, I think there are probably two different ways that are important to work at that. One is, as you said, education and just basically the knowledge that, in fact, the rates of risk are probably not substantially different between those populations. I think some of the regulations that have been in place perhaps were somewhat malinformed in the past by concerns in that regard.

We also have, basically, scientific approaches. The ability to do what's called nucleic acid testing – to look for evidence of DNA or RNA from, you know, HIV, hepatitis C, other different viruses and risks – those tests have improved dramatically, and as such we actually rely on that much more so than just, basically, the history. In many cases, much of the information that you get about a potential organ donor, which is relatively short-term information, where you're interacting with the family and whatever, is almost hearsay and second-hand, so I think we're far wiser to be relying on solid scientific evidence, where we can actually test for the presence of the agents that we're concerned about.

Member Irwin: Well, that's really helpful. Thank you. It's a topic I didn't know a whole lot about, so I really appreciate those words. I think those words should be passed on to those folks who have the decision-making ability to change those policies.

Dr. Kneteman: I agree completely. In fact, there are jurisdictions, for example, such as the U.S., where they have routine nucleic acid testing now for all their donors, and I think it's probably a much wiser approach than perhaps what we're doing in most of Canada. So there are things to improve.

Member Irwin: That's helpful. Thank you for that. I appreciate it.

The Chair: Thank you very much.

We will go now to the government member side. Anybody? No?

We can go back to the Official Opposition side. No? Okay.

Doctor, do you have any final comments?

Dr. Kneteman: Just that I think it was a little discouraging that when we had a bill passed several years ago to basically move us forward in these areas, we seemed to come to a screeching halt and not too much has changed over the last several years. I think we have an opportunity now to reinvigorate that activity, and I certainly hope that we take every advantage of it.

The Chair: Well, thank you very much, sir.

I'd like to once again thank Dr. Kneteman for presenting here today. Thank you again, sir.

Hon. members, before we turn to our next item on our agenda, which will be hearing stakeholders' presentations on Bill 207, I would suggest that, as per the agenda, we take a 30-minute dinner break, and we will return. So if the clerk could set the timer for 30 minutes.

[The committee adjourned from 5:43 p.m. to 6:13 p.m.]

The Chair: All right. Thank you very much. If I can have everybody's attention, please. Hon. members, ladies and gentlemen, welcome back. As we have a couple of stakeholders now joining us by teleconference, I would ask that members and those joining the committee at the table once again introduce themselves for the record.

Again, my name is Mike Ellis. I'm the MLA for Calgary-West and chair of the committee. I will now turn to my right, the deputy chair.

Mr. Schow: Joseph Schow, MLA, Cardston-Siksika.

Mr. Neudorf: Nathan Neudorf, MLA, Lethbridge-East.

Ms Glasgo: Michaela Glasgo, Brooks-Medicine Hat.

Mr. Sigurdson: R.J. Sigurdson, MLA, Highwood.

Mr. Horner: Nate Horner, MLA, Drumheller-Stettler.

Mr. Jeremy Nixon: Jeremy Nixon, Calgary-Klein.

Mr. Williams: Dan Williams, MLA, Peace River.

Ms Sigurdson: Lori Sigurdson, Edmonton-Riverview.

Member Irwin: Janis Irwin, Edmonton-Highlands-Norwood.

Ms Pancholi: Rakhi Pancholi, Edmonton-Whitemud.

Mr. Nielsen: Good evening, everyone. Chris Nielsen, MLA for Edmonton-Decore.

Dr. Massolin: Good evening. Philip Massolin, clerk of committees and research services.

Mr. Kulicki: Good evening. Michael Kulicki, committee clerk.

The Chair: Thank you very much.

Just for the record MLA Williams certainly has the right as a member of the Assembly to sit at the table. He is not a voting member. He will not be allowed to vote in any proceedings and cannot move any motions. That is just for the record.

Bill 207

Conscience Rights (Health Care Providers) Protection Act

The Chair: We will continue now with agenda item 5. That will be the review of Bill 207, Conscience Rights (Health Care Providers) Protection Act.

Hon. members, at our last meeting, on Monday, the committee agreed to invite stakeholders to provide oral presentations on Bill 207, Conscience Rights (Health Care Providers) Protection Act, and to accept written submissions with respect to this bill. The caucuses were requested to submit their lists of stakeholders to me by noon on Tuesday. For the record the opposition caucus requested to hear from Jillian Ratti and the Trans Equality Society of Alberta and Dying With Dignity Canada while the government caucus requested to hear from Dr. Ramona Coelho, Dr. Leonie Herx, and Dr. Kiely Williams. All the invited stakeholders indicated that they would be able to participate in today's meeting, so we will hear from them now. Since the two doctors, Dr. Coelho and Dr. Herx, are both calling from Ontario, we will hear from them first so that they are not kept waiting for so long this evening.

First, it's my understanding that Dr. Coelho is on the phone right now. With that, I would like to invite the doctor to provide her five-minute presentation, which will be followed by up to 15 minutes' worth of questions. Doctor, can you hear me?

Dr. Coelho: Yes.

The Chair: Thank you very much. You may begin your presentation. Thank you for being here.

Ramona Coelho

Dr. Coelho: Thank you. Good evening, everyone. I'm a family physician currently working in the province of Ontario, Canada, and I care for people living with chronic disabilities, severe mental health and chronic pain diagnoses, as well as refugees, my most recent arrivals having fled from Syria. I feel the need to clarify tonight that I have a wonderful patient population encompassing all lifestyles, including same-sex couples with children and trans people. I mention this only to allay fears that I've seen perpetuated in the media about people like me. All my patients are equally wonderful.

This bill is, rather, addressing the issue of doctors being able to retain their own identity and be true to their beliefs while continuing to practise medicine. Many physicians cannot participate in medical aid in dying based on their adherence to the Hippocratic oath or their deep convictions. In my years of home-care experience my patients' death wishes have arisen from many different things like depression or poor pain control, elder abuse, or unacknowledged existential fears. The cases of elder abuse that I have seen that led to a request for death would make me very wary about participation in medical aid in dying.

As well, many Christian, Jewish, Muslim, Sikh, and Hindu groups have endorsed the need for conscience protection in medicine in Ontario for their physicians. The Ontario college has stated that conscientious objectors should retrain in fields like sports medicine, that they should restrict their practices or leave medicine altogether. As someone who cares for numerous refugees who have recently found religious freedom, I find this conclusion intolerant and painfully distressing. I find that it goes against the principles of a multicultural, pluralistic society.

A true story I share is of a newly graduated Iraqi family doctor, whom I'll call Elaf. Her family fled from religious persecution in Iraq to Ontario. The entire family was elated and congratulated her on her new-found religious freedom. Elaf has done very well in Ontario, and she's gone on to do her medical training in family medicine. Now she and her family are realizing that she's not actually welcome to practise medicine freely in Ontario and that her religious freedoms will not be respected. She is not welcome to be who she is or to have her own beliefs.

In the area where I work, there are palliative care doctors who have stopped taking patients, have changed their practice, left Ontario, or retired early. The solution the CPSO chose to deal with this matter of differences has led to a diminishing of patient choice and access to important services and actually led to decreasing access to palliative care at the end of life. It also creates a homogeneous medical profession, with no representation of many minority groups.

On top of that, forcing referrals undermines conscience, which undermines patient care. As physicians we help our patients through many things in the context of a trusting relationship. We journey with them; we help them quit smoking and all those things. We also have to sometimes gently refuse requests for things like antibiotics when they have a virus. And we ask ourselves: "Why does a patient trust a doctor? Why does a patient trust me?" A

patient chooses to put their trust in a physician based on the belief that the physician is acting with absolute integrity and virtue in partnering with them. Would you trust your doctor if you felt they didn't actually care for you? This is called professionalism. I'm not just expected to show up for work and follow some algorithms and go home. It's much more that is being asked of me. I am asked to put all of my goodwill toward really understanding my patients, and this means that sometimes I have to disclose errors. Many of these things that require more of me every day cannot be dictated solely by rules and regulations. Those expectations: there's no audit that could make me fulfill them. They are inherent to patient-physician trust, and they are based on me using my conscience.

6:20

A physician who is asked to check their conscience at the door will end up being demoralized and burned out, as we've seen in Ontario, unable to carry the great responsibilities that the profession demands of them. In a pluralistic society with diverse beliefs, systems should be set up that are respectful of both sides. Alberta actually has a very good CPSA policy on this issue. You are very lucky. I urge you to enshrine your current CPSA policy into legislation as proposed by Mr. Williams in Bill 207 with amendments. I have taken the liberty of asking the clerk to hand you a longer submission of what I've just read to you as well as the CPSA agreement of amendments . . .

The Chair: Doctor, thank you very much. I hesitate to interrupt. We are under very strict timelines. Your five minutes have expired. It's okay.

As this is a government member's bill, we will now, as is standard practice, go to the Official Opposition for the start of our first 15 minutes. Member Pancholi, go ahead, please.

Ms Pancholi: Thank you, Mr. Chair. Good evening, Dr. Coelho. My name is Rakhi Pancholi. I'm the MLA for Edmonton-Whitemud. Thank you for being with us this evening to give us your thoughts.

Dr. Coelho, the first thing I should clarify is that the bill that is before this committee for consideration this evening is the original bill that was brought forward by the member. We are not in a position to consider any of the amendments that were brought forward at the last meeting. The bill that we are considering this evening is the bill as proposed. I just wanted to ask you, Dr. Coelho, if you could – and forgive me if I'm pronouncing your name incorrectly . . .

Dr. Coelho: No. You're perfect.

Ms Pancholi: Oh, good. Okay. Thank you.

I just wanted to ask whether or not you practise medicine in Alberta.

Dr. Coelho: No, I don't. I practise in Ontario. I was very clear on that one.

Ms Pancholi: Thank you very much.

No follow-up.

The Chair: Okay. Thank you very much.

Mr. Schow, go ahead, please, sir.

Mr. Schow: Thank you, Mr. Chair, and thank you, Doctor. I appreciate your comments this evening and just have a couple of questions for you. I believe that this bill is attempting to essentially staple in the status quo, and that doesn't change the reality on the ground. It simply seeks to preserve the reality on the ground in terms of conscience protection. Given that, is there any evidence of

current access gaps created by current policies which protect conscience?

Dr. Coelho: Do you mean in Alberta, or do you mean in Ontario?

Mr. Schow: I would probably say that maybe you can have a look at both sides if you're looking at Ontario or Alberta as a place to go.

Dr. Coelho: So long as there are budget cuts, maybe, but I'm in Ontario. I know that Eric Waslenko gave you guys a written submission. He helped create the care of co-ordination service, and I'm sure that he can answer that question more appropriately for Alberta.

In terms of conscience protection in Ontario, we don't have it, and that's the problem. We've lost our conscience protection, so actually doctors like me who are on the front lines – actually, I'm alone. It's not that I haven't looked for partners, but I work in a very marginalized population with a lot of people with homelessness and addictions, and it's very hard to find a group practice. What the government has said here is that I should leave family medicine and restrict my practice to protect myself. Instead of finding a system where a patient can still have direct access to services that I might not offer – and there are very few – they are saying that I should leave family medicine in its entirety and retrain.

The Chair: Mr. Schow, do you have a follow-up?

Mr. Schow: No, Mr. Chair.

The Chair: Okay. Thank you.

Member Irwin, go ahead, please.

Member Irwin: Thank you, Mr. Chair. You know, it's fair to say that you are a supportive doctor of queer and trans folks, and you noted that you have some of those patients, but not every doctor is the same. Respectfully, you're not in Alberta, so you don't have the Alberta context of shortages in rural Alberta, for example. Interestingly, there are thousands of doctors in Alberta, nearly 200 of which have signed a letter in opposition to Bill 207. The fact that the government wasn't able to find more doctors from our own province is an interesting thing.

But back to my question. You know, we've heard, I've heard from many trans folks in rural Alberta. One trans person reached out to me, and they said that – you know what? – they have one doctor. They have one doctor. What do they do if they're denied service? Bill 207 allows that. It allows the possibility of no referral. I just want your perspective on that. What do I say to trans folks like that one who are worried, who are scared?

Dr. Coelho: Yeah. That's a great question. I would say – let's see; it's a complicated question. Your first statement was that I don't know doctors in Alberta. I would say that I don't think that I'm such, like, a foreigner that I have no idea of the culture. I wouldn't say that Canada is so crazily different, that I am so culturally removed from you that I can't relate to you. That's my first statement.

My second statement. I would say that being a conscientious objector is not someone who is cruel and is not somebody – like, that's the stereotype, and especially the media has perpetuated that, right? It's not somebody who is – like, that's just a bad person, a bad doctor who doesn't actually care about the freedom of their patients. The professional relationship is, in my mind, so important and so fragile both ways, the exposure that we both have to each other. A conscientious objector should be somebody who cares so much about the issues of their patients' health that they can't bring themselves, for example, to make a referral for medical aid in dying.

For trans people this is – again, I have very clearly said that I'm in Ontario, but I can't imagine that it's so different. The intake for trans people in Ontario is through community mental health associations. Pretend that another doctor is not able to make a referral to a gender endocrinologist directly. The intake in Ontario – and I presume it's the same because it's a Canadian federal thing, as far as I know – is through psychiatry. Most of the people who come to us have been bullied and discriminated against, and they need supports, and there's nothing wrong with making that referral, I think, all around.

In fact, in the court case that happened in Ontario, there were many witnesses from around the world, and I think there were some from Alberta, and actually none of them had a conscientious objection to making that kind of referral.

Member Irwin: Yeah. I'll maybe interrupt you in the interest of time. I mean, I'm not certain you're answering my question. What do I say to that trans person? This isn't a hypothetical person. There are trans folks currently who are already experiencing barriers to health care in rural Alberta and not just in rural Alberta.

Dr. Coelho: Right. So you can tell them, because, of course, it's your own freedom to tell them what you want – I would tell them that this is meant to protect the doctors who are conscientious, not bad doctors. Bad doctors don't care about their patients. The college will still have a mandate to look at whether the doctor is a good doctor or a bad doctor . . .

Member Irwin: And in the meantime they're not accessing care.

Dr. Coelho: . . . and that's a different issue.

I think the media has very badly portrayed the bill. And I think the over 200 doctors should probably have read the bill . . .

Member Irwin: Oh, they have. We'll be hearing from them.

Dr. Coelho: . . . and not just signed a letter.

The Chair: Doctor, thank you.

Member, thank you very much for your question and comment.

We'll now go to Mr. Neudorf. Go ahead, please.

Mr. Neudorf: Thank you. Thank you, Dr. Coelho. Just two questions for you. The first one, if you don't mind: how long have you been in practice?

Dr. Coelho: I graduated in 2004 from McGill.

Mr. Neudorf: Thank you. And then the follow-up is: how much have you seen the laws and requirements . . .

Dr. Coelho: Oh, wait. I started practising independently as staff in 2006-2007. There was maternity leave in there, so I'm not sure if that . . .

Mr. Neudorf: Sure. No. That's fine.

Dr. Coelho: Okay.

Mr. Neudorf: It was more just to give context to the second question. How much have you seen the laws and requirements changed for physicians in your time?

Dr. Coelho: I feel that the changes in 2016 in Ontario have been very bad. Like, they've been drastic. I tend to mentor young medical students and residents. I used to teach at McGill. You know, young residents here don't feel free, first of all, to say what they actually

think. They're worried about being judged. There's an increase in bullying in hospitals because of this kind of legislation that is made. Your last MLA asked about that kind of association, which is, for the most part, a false association, someone hiding under kind of the label of a conscience objector. The truth is that most conscience objectors are actually conscientious. So a lot of them feel like they can no longer practise in hospitals, that they won't be welcomed in certain clinics.

Actually, it's been shown. Like, if you look at the parliamentary briefs that were entered in Ontario when this was going on – several people mentioned them – like Sunnybrook hospital's: bullying. Doctors had to have their own separate e-mails to talk about this. That change in 2016 has been very sad for us here in Ontario.

6:30

The Chair: Thank you very much, Doctor.

Member Pancholi, go ahead, please.

Ms Pancholi: Thank you, Mr. Chair. Dr. Coelho, the reason you're being – I believe the questions that we're directing are because there is a different context between what's happening in Ontario and what's happening in Alberta. So it is significant for the purposes of the consideration of the bill before us to be very familiar with what's going on in Ontario versus what's going on in Alberta, although I think we can agree that across the country there are protections for conscience rights under the Charter and it has constitutionally been upheld that there are some limitations on conscience rights. Of course, the framework that exists in Ontario is different than the one in Alberta, and therefore that's perhaps why we are questioning a little bit more about your experience within Alberta, because they are different contexts. To that end, my question is: are you familiar with the standard of practice on conscientious objection by the College of Physicians & Surgeons of Alberta?

Dr. Coelho: I have read it, not just today, not recently, but I have read it before. I think, actually, in the letter that I included is the CPSA's. There's a link – unfortunately, it's a paper that you guys have – to that document, which I have looked at before, and to the draft amendment that you said is not relevant for today.

Ms Pancholi: Then can you say what concerns you might have with respect to the standard of practice of the college of physicians of Alberta, what concerns you have with respect to that standard and how you feel it's addressed by the bill?

Dr. Coelho: Super. Actually, I said that in my talk, that you guys are very lucky. I actually think the CPSA has it right in terms of balancing patient and physician rights. The Canadian Medical Association released a statement when this happened in Ontario – and again, yes, I know I'm going back to Ontario – that this is a false dichotomy that has been created in Ontario. It's unnecessary. You guys actually have it right. I applaud your CPSA. What I'm saying is that what happened in Ontario to some of the physicians has happened now to the nurses, and it's happened to the pharmacists, and it's actually very bad for medicine. So if you guys have a chance to enshrine your CPSA policy, I would do it.

The Chair: Thank you very much, Doctor.

We will now continue with Mr. Nixon. Go ahead, please.

Mr. Jeremy Nixon: Thank you, Chair, and thank you, Doctor, for joining us here today. I'd hate to put words in the member opposite's mouth, but I'm going to try and rephrase what I thought I heard because it's my concern as well, as somebody who has

worked with vulnerable people for many years here in Calgary. I think one of the big concerns, certainly, that I've heard from my constituents and from people that I've been talking to is about: how do we protect people from discriminatory practice? Can you comment maybe a little bit on how that's changed in Ontario from before they put this law in and after they put this law in?

Dr. Coelho: Yes. I think, actually, this law is what they were – you know, presuming everyone has goodwill, I presume that that's what the CPSO was trying to do. The problem is that when you have somebody who is not conscientious and doesn't care about their patients, they're not following the rules, and this is affecting the doctors who actually care.

The second part of the question is: how do we prevent doctors from using that power, from abusing the vulnerability of our patients? I take care of all marginalized patients. I've worked with prostitutes and, like, many, many different groups. They're very vulnerable. How do we protect them?

I would say that my answer is that the history of professionalism is being lost. A lot of young medical students – and we shouldn't have to have these small groups of older neurologists who are, like: "Yeah, I lived at the hospital when I was a resident. My whole life was medicine." And the young residents are, "I can't relate to that." You know, I understand. They shouldn't, right? But there is something about this kind of giving of yourself, at least in the moments that you're there, the moment that the patient is in front of you, where you are fully engaged. That actually requires teaching medical students not just facts, not just algorithms but actually, by example and mentoring, what it means to open yourself up to the patient in a new and creative way. And that's actually an art. It can be helped. There is a predisposition for that. It's kind of like if we're the Grinch: our heart has to grow sizes. I think that that is through medical school and mentoring, and I think that that interacting is released.

But I don't think that the policy in Ontario . . .

The Chair: Okay. Thank you, Doctor.

Go ahead, please, Mr. Nixon. You've got less than a minute.

Mr. Jeremy Nixon: I appreciate the concern, Doctor. Again I'm going to just kind of emphasize in regard to: what is in place that currently protects people from discriminatory practice, and how does that change in this bill? How do you perceive that?

Dr. Coelho: Are you talking about in Alberta?

Mr. Jeremy Nixon: Yes.

Dr. Coelho: Well, what I'm saying is that if you create a bill like we have in – if you don't have a bill that enshrines your rights, then what happened in Ontario provincially could happen provincially in Alberta. If you have this chance to have regulation, then – this bill is actually about protecting the identity of the doctor, which is actually essential for the doctor, to continue without being totally burnt out and without being acted on in a way that is not fair to them. This is what this bill . . .

The Chair: Doctor, thank you so much. I certainly hesitate to interrupt. The 15 minutes have expired. I just want to thank you so much for your presentation, and I want to thank you for taking the 15 minutes to take questions from the committee members. I just want to say thank you and hope you have a good night. We have to move on to our next presenter, so thank you so much.

Dr. Coelho: Thank you.

The Chair: Thank you.

Next up, committee members and ladies and gentlemen, we are going to move on to Dr. Leonie Herx. I would like to invite Dr. Herx, who is also on teleconference, to provide her five-minute presentation, which will be followed by up to 15 minutes of questions.

Doctor, are you on the line, and can you hear me?

Dr. Herx: Yes, I can. Can you hear me?

The Chair: I can. Thank you very much.

You may begin. You have five minutes starting now.

Leonie Herx

Dr. Herx: Sure. I just apologize in advance. I'm just recovering from a viral infection. I've got laryngitis, but I hope that you can hear me okay.

My name is Leonie Herx, and I'm a palliative consultant. I recently relocated from Alberta to Ontario, but I did all my training and practice in Alberta. I was there for over 20 years. I've just been in Kingston, Ontario, for one year. I'm the division head of palliative medicine at Queen's University and the medical director of palliative care here in Kingston. I did my MD PhD program in Calgary, and that's where I did all my palliative medicine training. I had various leadership positions within Alberta Health Services, including contributing to the development of the program for medical assistance in dying within an acute-care setting with my other colleagues within the division of palliative care. So I have lots of context from my work in Alberta and new context, from my recent move to Ontario, in a different regulatory environment. I have numerous other roles that you can read in my written submission that would give me experience to be someone well able to be speaking on this issue.

First, I wanted to speak a word on conscience. We all have conscience that's informed and formed by our deeply held personal values and beliefs, that's influenced by culture, family, tradition, religion, and philosophy, that leads us all to have a world view and what I call a moral compass. Every Canadian is entitled to have their conscience rights protected and respected as laid out in the Charter of Rights and Freedoms.

This is what the proposed bill is regarding, to ensure that the minority of physicians and health care professionals who are not comfortable with some of the termination-of-life practices in Canada such as medical assistance in dying – that's what I can speak to more fully because that's an area that affects me on a daily basis – is still able to maintain their integrity and practise as physicians and have their conscience rights protected, as they're entitled to.

In palliative care every day we are challenged with rights of conscience. We work in a very complex environment with very challenging ethical decision-making, moral dilemmas. We work with patients in extreme cases of suffering who are dealing with their own dying and death. What's very difficult for us in palliative care with respect to medical assistance in dying is that the philosophy of palliative care and the value of our practice of medicine are actually in direct conflict with the underlying philosophies of medical assistance in dying. In palliative care dying is seen as a natural process and a normal part of life. Palliative care affirms life and does not hasten death, and obviously MAID is a direct termination-of-life procedure.

6:40

I just wanted to round out this discussion a little bit by saying that for palliative care physicians the matter of conscience rights and conscience objection is actually related to our core values and the

principles of our area of medicine as opposed to religious views. I know that a lot of opponents to this type of legislation will say that this is a matter of religion, and that's what happened in Ontario. That's actually not the case for many of us practising in palliative care. Many of us who are physicians object to medical assistance in dying because it's against our role as physicians and healers and the Hippocratic tradition. For some people termination-of-life practices like MAID, even participating in a referral, is a form of going against our conscience, providing access to a service that goes against our moral compass. So referral is indeed for some people a form of participation.

We do think that this issue of conscience is going to become a bigger issue for physicians beyond palliative care as the anticipation of the amendments to the legislation by the Trudeau government for Bill C-14 to accommodate the Truchon and Gladu ruling from this past September, which removes the clause for reasonably foreseeable death, has really paved the way for expanding MAID for any kind of chronic condition, disability, or illness, which therefore is going to have much broader implications around conscience rights for physicians well beyond palliative care, including geriatrics, pediatrics. It's going to affect a lot more people, and we're going to be struggling with this a lot more in medicine. Mental health is the other area.

Alberta has done a really good job of getting it right. I lived and worked and practised in medicine prior to the MAID legislation, worked through it and then post-MAID legislation. There was very diligent work done to create a centralized co-ordination service that worked for patients and families who wanted to access the service but also . . .

The Chair: Doctor, thank you. I certainly apologize for interrupting, but we are very limited to five minutes. It has now gone past the five minutes, so I thank you so much for your presentation.

We will now move to the next phase, which is 15 minutes' worth of questions asked by the committee members. Again we will start with members of the Official Opposition and begin with Member Pancholi.

Ms Pancholi: Thank you, Mr. Chair. Good evening, Dr. Herx. Thank you for joining us this evening. I just wanted to ask you a question. You indicated that you have practised medicine in Alberta prior to moving to Ontario, so I hope it's fair for me to then make an assumption that you're familiar with the standard of practice on conscientious objection from the college of physicians . . .

Dr. Herx: I absolutely am.

Ms Pancholi: Yeah? Okay. Then you would be familiar with the fact that the standard of practice indicates that where a member has a conscientious objection to providing a service,

the regulated member must ensure that the patient who seeks such advice or medical care is offered timely access to [either]:

- a. a regulated member who is willing to provide the medical treatment, service or information; or
- b. a resource that will provide accurate information about all available medical options.

Can you tell me what concerns you have with respect to that standard of practice, where the practice is clear that the regulated member must either refer the patient to another regulated member or a resource that will provide accurate information about medical options? What problem do you see with that that is being fixed by this bill?

Dr. Herx: What this bill is fixing is ensuring that that standard of protection is maintained for physicians. A regulatory body is not

the same thing as codifying something into law that maintains that protection.

What happened in Ontario is the regulatory body decided to change its mind. Different leadership that comes in can have different perspectives, and that's the risk that is currently in play for Alberta. Currently it's being done very well. That needs to be maintained, and the only way to maintain it, to really protect conscience rights for physicians through the standards set by the CPSA, is to legislate it.

Ms Pancholi: Thank you. A follow-up question. Even if that were the case, although, I mean, regulated members have input into their own standards of practice and can certainly influence it that way – however, I would assume, of course, since you have been asked by the member who is proposing this private member's bill to speak to this, that you must be familiar, then, with what's in Bill 207. So you'll know that Bill 207 does not just enshrine what is currently set out in the College of Physicians & Surgeons' standard of practice. In fact, it goes far beyond that by extending those practices to a number, any health service provider under the Health Professions Act, which includes things from social workers to therapists to counsellors to doctors to pharmacists, so it's much more extensive than what's set out here. Further, Bill 207 also prohibits and actually orders regulatory bodies to dismiss complaints made against one of their members on the basis of conscientious objection, which, again, goes far beyond what is – well, it's certainly not set out in the standards of practice for conscientious objection.

Wouldn't you agree that Bill 207 actually goes far beyond simply codifying what's currently in the standard of practice?

Dr. Herx: The amendments to Bill 207, which the CPSA has shared on their website . . .

The Chair: Sorry, Doctor. Dr. Herx, thank you for your comments. I just want to clarify for the member as well as yourself that the decision before this committee is the bill itself, not possible amendments that may come in the future. It is the bill that is before this committee. Thank you very much.

Okay. We'll now go to Member Glasgo.

Ms Glasgo: Thank you, Mr. Chair, and thank you, Doctor, for your time tonight. I acknowledge that you have been in Alberta for quite some time and just moved to Ontario. I'd like to just kind of touch on your Alberta experience, especially in palliative care. I'm just wondering if you could tell me approximately how many doctors in Alberta are in the co-ordinated care network and offer euthanasia and assisted suicide.

Dr. Herx: When I lived in Alberta – I left in 2018 – that information was not shared in terms of the numbers of people participating in MAID. It was kept confidential.

Ms Glasgo: Okay. If that information is kept confidential, would you say that maybe freeing up that information could improve access while still maintaining conscientious objection for those who don't wish to participate in that process if access is an issue?

Dr. Herx: I'm sorry. Could you rephrase the question? I'm not quite clear on what you're asking me.

Ms Glasgo: Sorry. I spoke too fast. If those numbers aren't given freely, if there's a way that we can free up those numbers, would we be able to protect people's conscientious objection by having greater access to those co-ordinated care networks? It's my

understanding that they're in abundance in Alberta and that it's really not that hard to find someone to perform the procedure, meaning that access isn't actually an issue here for this particular procedure.

You've also mentioned that palliative care practitioners are not necessarily opposed on religious grounds but based on their training. I was just wondering if you could elaborate on that.

Dr. Herx: Absolutely. Alberta has done a great job of having a centralized co-ordination service. That can be done in other provinces as well, and certainly our Canadian Society of Palliative Care Physicians looks to the model in Alberta and recommends in other provinces that the way to reconcile the rights of physicians is to not have to participate in referral because referral is actually not necessary to provide access. Alberta has already shown that. I'm not sure that you need to know the numbers of people who provide such procedures; you need to have just an open access co-ordination system to hook up people who are interested in that service with a provider. That could be done for any health care, especially controversial health care practices that are very ethically challenging. I'm not sure if that answers your question or not.

6:50

The Chair: Thank you very much, Doctor.

We'll go to Member Sigurdson. Go ahead, please.

Ms Sigurdson: Yes. Thank you very much, Doctor, for joining us. My profession is social work. This bill that's before us actually pertains to 28 other professions, so several different kinds of professions are impacted by this. I'm just going to quote a little bit from the social workers' code of ethics. It says:

A social worker's personal values, culture, religious beliefs, practices and/or other important distinctions, such as age, ability, gender or sexual orientation can affect his/her ethical choices. Thus, social workers need to be aware of any conflicts between personal and professional values and deal with them responsibly.

Certainly, you know, we're very focused, as you are as a doctor, on making sure that our clients, as we call them, get the support that they need. If we have a conflict like it says in this, then we must responsibly deal with that, and certainly one of the ways that we'd responsibly deal with that would be with a referral system so that we make sure that someone gets equivalent kind of care from another professional of the same level. I feel like that's one of the key pieces that's missing in this bill, and I just wanted your comments about that.

Dr. Herx: Actually, a referral is not necessary for people to have access, and Alberta has already shown that in the system that's set up for MAID. Patients can self-access. You can call 811. You can get access yourself. You do not need a referral.

Both the Canadian Medical Association and the world medical association have set up and protected the rights of doctors to not have to do referrals when it comes to practices that go against their conscience, specifically euthanasia. That's what your CPSA already supports and what processes are already in place in Alberta, that need to be codified into law to ensure that they remain that way to protect the minority. It's true that society is changing. People are more accepting of different termination-of-life practices. But, you know, the Charter of Rights and Freedoms is there to protect the minority, and that needs to be considered when it comes to medicine and health care professionals not being forced to participate in something that goes against their conscience.

To answer the previous member's question, in palliative care it is about the philosophy of care, that it is not hastening death. Therefore,

it may be in direct conflict with the underlying philosophies of palliative care, which is why many palliative care physicians do not want to participate in MAID, including a referral.

Ms Sigurdson: Okay. Thank you, Doctor.

The Chair: Thank you, Doctor.

Member, go ahead, please, with a follow-up.

Ms Sigurdson: Yeah. Certainly, a phone number isn't a referral. A referral is, you know, having someone – in my profession that would just be completely insufficient. Someone with experience would need to be working with that person, so that is not an adequate response to supporting someone through whatever health needs that they have. I mean, perhaps you're saying that it is what the docs need. That's not true for social work and, I think, many other professions, and I really do question it regarding doctors.

Dr. Herx: I would just add that providing information for patients to understand their choices and what's legally available and appropriate for them is a professional responsibility of a physician that we would all uphold. That's very different than providing a referral. Providing information to ensure that people know what they have a right to and how they can access it, of course, is a standard of care that everyone adheres to and that this still supports.

The Chair: Thank you very much, Doctor.

Mr. Horner, go ahead, please.

Mr. Horner: Yes. Thank you for being with us tonight, Doctor. I guess we've heard from a few presenters tonight. The MAID, or medical assistance in dying, program is a consistent theme, and I can see how that goes against the Hippocratic oath. This is relatively a new legal procedure, so I can definitely see how for many physicians, you know, this might be something that they didn't sign up for. In your opinion, is this too broad, what's trying to be done here? Should we be looking at that act itself instead of going towards something hard to define like a conscience right? We haven't talked about abortion much tonight, but many people fear that this is somehow trying to access other legal procedures and that there could be reverse discrimination against the Charter. I guess I'm just looking for your thoughts.

Dr. Herx: Well, I think that we need to always keep in mind that this is about physicians and health care professionals' ability to have integrity as human beings and maintain their vocation. Euthanasia, or MAID, is one example of a very controversial, ethically challenging practice, that is more recently in the media because, as you've said, it's recently legislated. However, the landscape for euthanasia is changing, and it's going to be changing much more suddenly in April, beyond the Truchon and Gladu case, and extend well beyond what the Supreme Court envisioned with progressive, kind of life-limiting conditions of people at end of life. Now we're talking about people that have potentially decades left to live and mental health as a primary diagnosis.

Certainly, my frame of reference and the conscience rights that I experience as a challenge on a daily basis do relate to MAID, but there are many – you know, it's a minority of physicians. There are some physicians and other health care professionals that also struggle with other termination-of-life practices like abortion, and those do need to be taken into account when you're talking about protecting a person's Charter rights. There's no current way that that's being protected in provincial legislation.

Mr. Horner: Thank you.

The Chair: A follow-up, sir?

Mr. Horner: No, thank you.

The Chair: Okay. We'll go back to the Official Opposition. Go ahead, Member Irwin.

Member Irwin: Thank you. I'm worried about patients, and I'm worried about patient rights. I'm particularly worried about vulnerable patients' rights. We know, to put it frankly, that for vulnerable patients a referral is absolutely needed. Again, I've shared my concerns, particularly about the trans community, someone who is in a remote part of the province. They need a referral. We know that delayed care is less safe care, and there are countless examples of trans folks being very much in jeopardy because of lack of access to the health care they need. I just want you to clarify for us. How does this bill specifically protect patients? How does it protect that vulnerable trans patient in rural Alberta, for example?

Dr. Herx: This bill is actually a reconciliation of the rights of patients with the right of health care professionals to maintain their rights as well. It's a reconciliation of both rights: patients to access, and health care professionals to have their own integrity respected as well, as we are all entitled to. There are lots of examples of systems that can be put in place, including a recent one that was published in the province of Prince Edward Island, where there was no access to abortion services for women, and within a 10-month period they've now set up a complete system for abortion and women's health that's self-referral and accessible without referrals. Just like the co-ordinated need service in Alberta, you can actually call the central navigation number, and they determine the best person for you to be with and provide you access.

Furthermore, we're using virtual technologies every day now in medicine, including within . . .

The Chair: Okay, Dr. Herx. Thank you. I apologize to interrupt, but it has exceeded 15 minutes. I just want to thank you so much for participating via teleconference. I want to thank you so much for your presentation, and I also want to thank you for answering the questions by the committee members. Certainly, we hope you have a great night. Thank you very much.

We must move on to our next presenter. Ladies and gentlemen, members of the committee, we are now going to continue with Dr. Kiely Williams. At this time I'd like to invite Dr. Kiely Williams to join us at the table to provide her five-minute presentation, which will be followed by up to 15 minutes of questions.

I'm understanding that Dr. Williams is here. If you could please go to the table there. Doctor, thank you so much. When you are ready, you may begin.

7:00

Kiely Williams

Dr. Williams: Thank you for having me. Good evening. Thank you for allowing me to speak to Bill 207 today. My name is Dr. Kiely Williams, and I'm a family physician in Calgary, Alberta. I also provide rural emergency medicine services. I would like to express my full support for Bill 207. The primary reason I support this bill is because it will legally protect the current balance of freedoms evident in our health care system. The College of Physicians & Surgeons of Alberta has expressed that this bill will not change their function as a regulator and that this bill is aligned with the current standard of practice with respect to conscience

objection. To vote against this bill is to vote against the current standards of the CPSA.

We must understand that this is not an us-versus-them argument. Every physician is a conscientious objector to something. Each of us has something we will not participate in because we do not believe it to be in the best interests of our patients. We must understand that each of you on this committee will either vote to add legal protection for the freedom of conscience for all health care providers or you will vote to deny legal protection for the freedom of conscience for all health care providers. Simply because we have freedoms does not mean that they cannot be taken away if we do not protect them. There has been great concern about the health care access for specific patient populations if this bill were to proceed. We have members representing the LGBTQ2S-plus community here.

I would like to point out that I am a conscientious objector, and I in no way want to impede access to services that I believe to be in the best interest of my patients. I'm also a PREP provider. For those of you who do not know, that's a combination medication that reduces the risk of HIV transmission and is primarily used in the LGBTQ community. To prescribe this medication requires additional training. I'm one of a few physicians in the province who has taken active steps in her practice to reduce barriers to access and care, and I am asking for legal protection for conscientious objection. Conscientious objectors are not interested in limiting access to services. Our health care system has made multiple points of access, and referral is not mandatory for many services that health care providers may object to. If we do not support this legislation, we may find ourselves in a difficult position one day. As we have seen, the makeup of both governments and professional regulatory bodies can change drastically and quickly.

To illustrate my concern, I want to give a hypothetical example. I also want to make clear that I am not endorsing, suggesting, or promoting the following example. It is an illustration only. I want to illustrate how voting against this bill could adversely affect members of the trans community. Consider for a moment a medical regulatory body who required patients to complete a course of conversion therapy before being permitted access to gender reassignment surgery. I would imagine there would be a large number of physicians who would object to this and not want to be complicit in it. If we do not pass this bill and do not add legal protection to our current system, every single doctor this patient sees could be required to refer them for conversion therapy, even those who object to this. Where is the patient supposed to go then? Even if the patient has requested conversion therapy, the physician may still believe that it is not in their best interest, and the physician may not want to be complicit.

We may think that this is an unlikely scenario and could never happen. But three years ago it was illegal and considered medically unethical for physicians to be involved in the active, intentional death of their patient. Today that's a part of medicine in Canada. Laws and medical ethics can change quickly when they are not protected. Like I said earlier, we either protect freedoms together or we lose freedoms together.

I will give a real-life example now. I have a close friend who is a MAID provider. This physician also strongly supports the Charter right to freedom of conscience. I have another colleague who provides neither MAID nor PREP. He is a rural physician who is a conscientious objector, and he has written to this committee. He has 1,200 patients in his family medicine practice. If conscientious objectors are not protected, this will impede access for many Albertans to many services. We will lose a MAID provider, a PREP prescriber, and rural physicians. Many patients would lose access to the care they have right now.

I will end with why we need legislation to protect the system we currently have, a system that has balanced the mutual freedoms of all Albertans for many years. The only reason we're having this discussion is because of the situation in Ontario. Prior to this recent change in Ontario we physicians believed that the CPSA standard of practice was enough. Now we have a clear, real-life example that the protection we currently have is not sufficient. Our standard must have legal protection through Bill 207. It's very important to understand that conscientious objectors in Ontario were never told that they had to agree with what they were objecting to. The college and the courts accepted that they believed certain acts to be deeply wrong.

The Chair: Doctor, thank you so much for your presentation.

We will now go into the next phase, which is 15 minutes of questions and answers. We will begin with the Official Opposition.

Member Irwin: Thank you, Dr. Williams, for being here. Your hypothetical example: you know, we've already heard tonight that doctors are already protected, and you're talking about a caring doctor who is going to support that trans person in their journey, okay? I'm telling you that I've got nonhypothetical examples. I've got real-life examples. I've got somebody in the crowd who is a member of the LGBTQ2S-plus community who is very worried. She hasn't been denied care, but she has friends who have been. This is happening. This is happening in rural Alberta. This is happening in remote parts of Alberta. It's happening in Edmonton. So to provide a hypothetical example and to say that it puts a doctor in a conflict: that doctor is already providing the services. I'm worried about our most vulnerable Albertans, who are already being denied care in some cases, and this bill, without the provision for referrals, is just going to worsen that. What can you say?

Dr. Williams: First of all, I thank you for your incredible compassion because it's so evident, and I think we need more of that. I hope that I can convey that to you tonight, that I'm a conscientious objector and I'm so compassionate to the people around me. We had somebody earlier who said that the people who are doing what you're describing are not conscientious objectors; they're "bad doctors." I believe that if we don't allow the protections for people to object, my point is that we'll lose it for everyone. Regardless of where we stand on certain issues, we have to protect freedoms because if we don't protect the freedoms for everybody, we lose the freedoms for everybody.

Member Irwin: Well, I'm worried about the freedom and the rights of those vulnerable Albertans, truly.

To move on to another nonhypothetical, I've heard from countless women, in particular, in rural Alberta who face barriers to reproductive health services. One woman in central Alberta said that she was denied birth control. And, again, this is happening in 2019 in rural Alberta. Women are being turned away, right? This bill is only going to worsen this.

Dr. Williams: Is that a question?

Member Irwin: Well, I mean, it's happening. We've got multiple doctors in the crowd; we've got a rural doctor in the crowd who says that she's concerned about Bill 207, that clearly it's unnecessary. We've already heard other folks say tonight that it's unnecessary. What do I say to those women who have reached out to me, who have shared their stories? They're already experiencing significant barriers to reproductive health. What do I say to them?

Dr. Williams: Access to medical care in rural Alberta is problematic across the board for almost every single medical service. That is a huge, huge issue. We will not solve that issue by getting doctors to act against their conscience. What we will probably do is make it worse unintentionally. I think that your passion is fantastic, but if we don't protect these freedoms, we are going to have unintended consequences.

The Chair: Thank you, Doctor.

Mr. Schow, go ahead, please.

Mr. Schow: Thank you, Mr. Chair, and thank you, Dr. Williams, for being here this evening with us. I have a question. A lot has been said about what could be the case in rural areas, as we've talked about just recently, if there's only one doctor in the community. But what are the implications if a policy requiring the violation of conscience were to be imposed? What would be the implications if a rural doctor decided they could not do something that they didn't believe in or that they believed to be wrong and therefore left the community or the area of practice?

Dr. Williams: Well, I believe you've answered your own question. That was one of the points that I was trying to make. By not adding the legal protection to the CPSA policy, we run the risk of having a system that could try and force doctors to violate their conscience, as we've seen in Ontario. In Ontario those doctors ended up leaving their practices. If there was a problem in accessing health care before, the problem in accessing health care is much worse now for many, many more patients than it was problematic for in the beginning.

Mr. Schow: My supplemental here, Mr. Chair: do you think it is possible that physicians are avoiding or will begin to avoid rural medical practices for fear of being required to violate their conscience?

Dr. Williams: Well, we've heard that that is happening in the one outlier that does require this. We do have a real-life example of Ontario, where that is the case because they did not protect what the college has instituted with legislation, which is what Alberta is being asked to do now.

7:10

Mr. Schow: Thank you.

The Chair: Thank you, Doctor.

Member Pancholi, go ahead, please.

Ms Pancholi: Thank you, Mr. Chair, and thank you, Dr. Williams. I just wanted to clarify. I'm a little kind of astounded because there's an element of a threat to what you're saying right now, as if doctors will threaten to leave and not serve their patients if we don't pass this kind of a law, which I can't imagine you're suggesting because I think most individuals that I know that go in to practise medicine and the people that we hear from care passionately about their patients. It sounds like there's an underlying threat there.

But I actually just want to go back to, again, a question that I've asked the previous stakeholders who have spoken this evening. I don't hear from you – and correct me if I'm wrong, Dr. Williams – that you are concerned with the current standard of practice from the College of Physicians & Surgeons of Alberta but, rather, that you just believe that it should be enshrined in law. But as I've stated with earlier stakeholders, Bill 207 in its current form, not the amendments because those are not before the committee tonight but the original bill that was provided, goes far beyond what's set out in the College of Physicians & Surgeons' standard

of practice. It extends to 28 regulated professions and includes in its definition of conscientious belief cultural traditions, that a medical provider or a health professional can deny service on the basis of a cultural tradition. It actually removes the right of patients to make complaints to its regulatory body if a provider refuses to provide a service on the basis of conscientious objection. It actually directs those bodies to dismiss those complaints, so you would not even really be able to track whether or not people were complaining about that. I'm wondering, again, given that that is what's contained in Bill 207 – and it goes far beyond what's contained in the standard of practice – is that still what you support, what's in Bill 207?

Dr. Williams: I must say that I'm a physician; I'm not a politician. So I look at the spirit of what's behind all of the information that I have in front of me. I know that maybe you can't access the amendments, but I can. And I understand that.

Ms Pancholi: The bill that's before us is the bill, and you're here as a stakeholder to ostensibly speak to Bill 207.

The Chair: Member, let me just clarify for the doctor.

Just pause the clock for a second, Clerk. Okay.

We would never presuppose the outcome of a committee meeting, and we will never presuppose the outcome of the Assembly under the second reading. Those amendments would only possibly apply in the future in something that is called Committee of the Whole, which we are nowhere near being close to. What we have before us right now is Bill 207 as it is.

Start the clock.

Go ahead, Member.

Ms Pancholi: Thank you. Dr. Williams, my follow-up question is simply – actually, you made a statement that I agree with. You said that just “because we have freedoms does not mean that they cannot be taken away.” When I think about that statement, I think about the freedom that women have under section 7 of the Charter to security of the person. I think about the freedom of equality that trans people, that LGBTQ2S people have, and that those rights need to be protected. And you're right; just because we have those rights – and we actually have a Supreme Court of Canada decision which protects the right of individuals to seek medical assistance in dying; that is a legally established right – doesn't mean it can't be taken away. The reason I know that is because of this bill that's been introduced. We are seeing a bill introduced that is actually going to chip away and actually goes right to the heart of taking away those hard-fought freedoms for women, for LGBTQ people, for people who are seeking medical assistance in dying. Those are protected rights under the Charter.

The Chair: Member, I ask you to please get to your question.

Ms Pancholi: My question is: how do you justify taking away certain rights but not others? I think I can agree with you that we need to protect all rights, but what you're proposing here takes away those rights, and I'd like you to speak to that.

Dr. Williams: Sure. All I can say, with everything that you've just said to me, is that you've completely misunderstood why I'm here tonight. I have no idea where you got a threat out of anything that I said, and I have no idea where you got me hoping to remove rights of women out of anything that I've said. That's absolutely not what I'm here for. That's absolutely not what I believe the intention of this bill to be. What I believe the intention of this bill to be is to protect rights that people already have and to respect the rights and

balance the equal freedoms of health care providers and their patients. That's what we need to do. We need to figure out how we're going to maintain the freedoms of everyone involved. I believe that's the spirit of this bill.

The Chair: Thank you very much.
Member Glasgo, go ahead, please.

Ms Glasgo: Thank you, Mr. Chair, and thank you, Dr. Williams, for being here today. I think your passion is also very evident, so I just want to point that out. I think it's come across very clearly in this committee that you care about the people that you're treating.

I'm interested in your position because I am one of – and actually I've been counting – about five of us on this side who come from rural areas. In previous meetings of this committee we have talked about things such as access to medical assistance in dying or anything like that. What I'm hearing from you is that access is also a concern to you. I was just wondering if you could elaborate on your comments on the 1,200 patients, on the one doctor who has 1,200 patients in rural Alberta. I can sure say that in my constituency we couldn't afford to lose a doctor right now. I don't take that as a threat; I take that as a reality. I'm just wondering if you could speak to that.

Dr. Williams: Sure. I mean, to be honest, I don't want to go backwards here, but I was very much caught off guard with the assumption that what I'm saying here tonight could be in any way construed as a threat. That was a big surprise to me. What I'm trying to paint a picture of is the reality of where we're at. What I'm trying to get rid of is the fear, I think, that's behind this. What I'm trying to say is that we need legal protection for the balance of freedoms that we already have so that we can keep offering the services that we have been offering and that we can look for creative solutions on getting rid of the many areas where we've identified gaps in our health care system for many different populations. I'm hoping that this bill will allow us to go forward, not backwards.

I hope that answers your question.

Ms Glasgo: Absolutely. It does.

The Chair: Do you have a follow-up?

Ms Glasgo: I do have a follow-up. Thank you, Mr. Chair. The previous speaker alluded to this as well. You were talking about, like, a culture of fear and doctors being worried. I have a doctor in my riding who practises at the Medicine Hat hospital. He practises in obstetrics, and he feels as though his rights or his abilities as a doctor to do no harm could be taken away at any moment with something like Ontario coming in. Also, I know that there are a lot of people coming to Canada with hopes of becoming doctors or coming to Alberta with hopes of being doctors. Do you see the threat of something happening like it did in Ontario as a hindrance to people coming to Alberta to practise medicine?

Dr. Williams: I can say that I've spoken with physicians from Ontario who are looking to move to Manitoba because Manitoba has conscience protection. Again, not threatening at all; I'm just saying what my experience has been. Physicians do not want to be compromised. I hope that this bill will allow me to be seen as a human person and not to become a technician of the state. I realize that that's not where we're at right now, so I'm asking for legal protection so that we do not get there.

The Chair: Thank you very much, Doctor.
Mr. Nielsen, go ahead, please, sir.

Mr. Nielsen: Thank you, Mr. Chair. Thank you, Dr. Williams. I appreciate you being here this evening to chat with us. Just to let you know, my background is in labour, so I've dealt with language a lot. When I look at Bill 207 right now, some language that I see that's being proposed – of course, it's not passed – suggests that complaints, should they be presented to the college based on conscientious rights, would immediately be dismissed. I know you had mentioned a little bit earlier about rights being taken away. Are you concerned that that language, as it's currently proposed, would potentially set up for other things, other complaints to be dismissed? You know, as they say, once you open up the floodgates, is there more? What are your thoughts on that?

Dr. Williams: Well, first of all, I should say how much I appreciate these thoughtful questions tonight. That's excellent. Straight across the board you guys have obviously been very invested in this. What I would say is that there could be room for improvement. I can't say exactly or not. I'm new to this. My understanding is that if this bill goes forward, it will be perfected, so to speak.

Mr. Nielsen: I can't presuppose that at this point in time.

Dr. Williams: Right. Sorry. My apologies. I guess that's maybe why I'm here asking for that tonight.

To answer your question about concern about dismissal of complaints, any complaint that the college gets, they have to investigate. They have to. Not fully investigate necessarily, but they have to look at it to see if it meets certain criteria. So they can't just throw it in the garbage right away. They have to go through a certain process to see if it's something they could get rid of.

Mr. Nielsen: I would absolutely agree with you on that based on, you know, the discussions that I have had with the college, but this language, should it be implemented, would say that any complaints based on conscientious beliefs would be immediately dismissed. Is that a problem?

7:20

Dr. Williams: First of all, they would have to see if it meets criteria to be dismissed for that.

Mr. Nielsen: But it would be that as soon as the title "conscientious beliefs" is there, it's immediately dismissed.

The Chair: We've got about 20 seconds left.

Dr. Williams: That's not my understanding of how the college would proceed with this or how the college is able to proceed with this.

Mr. Nielsen: I have to go based on what I see as the current language and tapping into my labour background.

Dr. Williams: Sure. I understand. Thank you for your insights.

The Chair: Okay. We've got about five seconds left. I want to thank you very much. I'd like to thank the government members as well. Doctor, I'd like to thank you for your presentation. Thank you for taking questions and, of course, answers from the committee. Thank you so much.

We are going to move on to our next presenter. I'd like to invite Dr. Jillian Ratti to join us at the table and provide a five-minute presentation, which will be followed by up to 15 minutes of questions.

I see the doctor is ready. Thank you for being here. The floor is yours when you're ready.

Jillian Ratti

Dr. Ratti: Excellent. Thanks for having me here today. I am Jillian Ratti, and I'm a family physician and a medical abortion provider in Calgary. Today I'm going to focus on access to abortion and reproductive services, and I will speak on behalf of nearly 200 physician signatories to a letter calling on this committee to kill this bill entirely. I'm also going to speak as a physician who deals daily with moral distress and as a woman who has had experience as a patient in our system as well.

First, I'll speak on behalf of my cosignatories. I'll emphasize that while we don't represent the Alberta Medical Association, the AMA has come out opposed to this bill, and the majority of physicians in this province do indeed oppose this bill. The main reason for that is because patient access to legal medical services like abortion will absolutely be reduced, especially for vulnerable and rural populations, who already have trouble finding a sympathetic doctor or the transportation to travel long distances to access services. The current system whereby objecting physicians must make sure that their patients have some kind of resource to help them access abortion is already insufficient. There are already providers who do not meet the standard of practice laid out by the CPSA.

Imagine a 15-year-old girl who has become pregnant following a sexual assault who goes to their physician, the only one in town, and is told: "No. I can't help you. Go call this number." She's now been abandoned by the medical system that's designed to be there for her. At the very least, the mental health consequences for this patient would be significant, and it is absolutely the kind of thing that I have seen drive teens to self-harm and suicide. Make no mistake; this is happening in Alberta. By removing the ability for patients to complain to our regulatory body about their own abandonment, it makes that kind of abandonment acceptable. The frequency of this kind of situation will absolutely increase as a result of that.

The argument that patients can self-refer for abortion services misses the major point, that patients in this situation are sometimes distraught and less able to navigate a system that feels very complex at the best of times. Physicians and health care providers are supposed to be there to provide comfort and guidance when the chaos of life prevents patients from knowing how to proceed. Even if doctors who object are not trying to be mean, their perceived judgment is harmful. We need to refer.

I'm going to switch over and focus more personally, not speaking as a representative of somebody who has signed a letter. I'm going to tell you a personal story about being denied access to care. About 20 years ago, after a less than ideal sexual experience, I went to a pharmacy to get the morning-after pill. The pharmacy tech told me to wait because he would have to ask, and he didn't think it was going to be possible. He went into a backroom and had a conversation with a pharmacist that I have never seen, who never came to look at me, and he came back and told me that that pharmacist objected and wouldn't and that I was going to have to find somewhere else to go. In that moment I was already scared and not knowing what to do. The rejection by this nameless, faceless person made me feel dirty and judged and less than human. A stranger that had never seen me was telling me that I deserved to get pregnant. I don't wish that on anybody, and this bill gets in the way of that.

I'm going to end by noting that this whole debate around so-called conscience rights ignores the fact that my conscience dictates strongly for the provision of abortion. I'm a provider of medical abortion because my conscience very much dictates it. Bill 207 selectively and purposefully ignores the very real conscience issues for pro-abortion health care providers and co-opts the issue of

conscience for other purposes. If you wish to legislate about conscience and moral distress in health care providers, you must speak with pro-abortion providers about theirs.

I urge the committee to kill this bill completely given that it has not at all consulted on the depth and breadth of the meaning of conscientious medical practice. Overall, I believe that legislative resources should be used to the benefit of vulnerable populations and not people like me, but if you must focus on us and our needs, go back to the table and do this right. However, if, as I suspect, you actually wish to have us all talk about whether abortion should be accessed at all, then I request you have the courage to do that directly instead of co-opting a conscience argument as if it doesn't apply to the rest of us.

Thank you.

The Chair: Doctor, thank you very much for that presentation. It was a very passionate presentation. I thank you immensely.

We will now continue with the 15 minutes of Q and A. We're going to start with the Official Opposition. Member Irwin, go ahead, please. Thank you.

Member Irwin: Thank you, Chair. Thank you, Dr. Ratti, for being here today. Your words were powerful. I appreciate so much that, you know, you prefaced your point by saying that you're not speaking entirely on behalf of the Alberta Medical Association but that you are sharing the concerns of 200 doctors across Alberta. We've heard from countless doctors. There are a number of doctors in the crowd who are absolutely concerned about this bill. I really appreciated your personal story as well, noting that you're someone now with privilege, that you can navigate the system. But we know that a whole lot of folks out there – and I've heard from them – don't have that privilege. Whether it's accessing abortion or trans health care, can you just talk a little bit more about the vulnerable, the marginalized patients that you serve and some of the barriers that you see them facing every day? This is pre Bill 207, to be clear.

Dr. Ratti: I've got lots of examples. As a medical abortion provider I struggle finding pharmacies that will fill that prescription for anybody who wishes to take it. We always have to call ahead and make sure that we can try and provide an experience that is not judgmental for that person. I've had too many situations where a patient shows up at a pharmacy, very much how I did – so it is indeed personal for me – and is having a situation where they're feeling judged or told to go somewhere else. I mean, that's one of them.

I also have trans patients in my practice who have come to me saying – you know, essentially every trans patient I have has a story about how they've been treated horribly in the medical system and told to fend for themselves in some way.

I guess those are the two most prominent examples that come to mind.

Member Irwin: And you're practising in Calgary in 2019 . . .

Dr. Ratti: And I'm urban.

Member Irwin: So you're in an urban area, and you're saying that you're finding it hard to find pharmacists who will provide reproductive health services for folks. Again, I think we can compound that in parts of rural Alberta. I guess, to counter some of the comments that we've heard from other doctors, what do you say to them when they argue that there won't be additional barriers in place for these folks?

Dr. Ratti: I think that that is living in a world that I don't live in. When you have a vulnerable patient in front of you, you need to be

able to assist them to access resources. You can't just say: here's a phone number; go figure it out. These are people who are coming to you in distress, and if we abandon them in that moment or if they're perceiving that we are abandoning them, we are not doing our job, and we are not up to standard of care.

The Chair: Thank you very much, Doctor.

Mr. Jeremy Nixon: Thank you very much for being here today. I'm a big supporter of conscience rights – I think that they're very important; obviously, they're enshrined in our Charter of Rights for that reason, because of their importance – including your conscience rights, so I appreciate your comments.

I also appreciate your comments about using government resources for vulnerable Albertans. As somebody who's worked with vulnerable Albertans for my entire career, I certainly think it's something that the government should be focused on advocating for. However, we are here for all Albertans, which would include you. I was curious about your comments about going back to the drawing board on this bill, and I'm wondering if you have any specific recommendations on that and if you can kind of comment a bit on how we go about balancing the right for access with the rights of conscience. Maybe that was too much to throw at you at once.

7:30

Dr. Ratti: No. I think I understand. I think my preference would ultimately still be to not go down this road at all because it is my firm belief that this is around reopening a discussion around reproductive rights. I think that's really the most important point I can make there.

In terms of what I said about going back to the drawing board, if you're going to talk about conscience rights, we need to include pro-abortion providers and talk to them about the moral distress they are feeling when they have to encounter pharmacists who won't help them.

You know, this is a tough, tough area, and ultimately I think the way Alberta has dealt with it has been pretty good up to now. I mean, it's not going to be a secret that I think Ontario does it better, but I think Alberta has not done it too badly. Even some of the previous people who testified here say that we're doing it pretty good. I see no reason to make changes about this, nor do I see a reason to legislate what we have right now.

The Chair: Mr. Nixon, do you have a follow-up?

Mr. Jeremy Nixon: For sure. We've heard a bit tonight some examples about discriminatory practice. I really, actually appreciated the previous presenters, that in their heart they don't want to see discriminatory practice. They referenced bad apples, if you will. What are we doing now? What can we do better going forward, from your perspective, in regard to dealing with this as an issue?

Dr. Ratti: I think that the people who testified before me were a little bit preoccupied with the idea that they were being perceived as bad doctors. I'm not sitting here saying that they are mean people or bad people, but I am saying that when, in that moment, they have a moment where they can't do something for a patient, that patient is going to feel something because of that. If they sit there as the person in power in that relationship and say, "I'm sorry; I don't believe in what you're asking me; I can't help you," that is a huge blow to a vulnerable individual. Even though that physician is not trying to do harm – I don't believe they're trying to do harm at all – I don't think that they are cognizant enough of the harm that that moment is doing to people in and of itself. That's why I firmly believe that referral is important without judgment.

The Chair: Thank you, Doctor.

Ms Sigurdson: Well, thank you very much for your presentation today. One of the things that I'm curious about your thoughts on is just the definition of conscientious beliefs in the bill. Certainly, I think there were over 400 submissions we got on Bill 207, so obviously Albertans are engaged and concerned and presenting their things. Some of the concerns presented were that in this bill the definition is very broad. It is sort of not found in any human rights code in this country at any sort of provincial, territorial, or federal level. It even includes cultural traditions. I don't know if you see any sort of concerns about that with that broadness. It goes beyond what we usually think of as someone who is a conscientious objector, that whole definition.

Dr. Ratti: Yeah. I mean, it's very broad and very vague, and I feel that there's a lot of scope for harm, even in a lot of unintended areas. If we have a Jehovah's Witness physician who is against blood transfusions and they are suddenly the first and only person around when a car accident victim needs a blood transfusion, then what? What happens here exactly? There are tons of unintended consequences, I suspect, out of the broadness of that definition.

Ms Sigurdson: Just a follow-up, if I could. Right now, I mean, physicians are allowed to conscientiously object about certain areas. Just your understanding of what the limits are on that now.

Dr. Ratti: Yeah. What I learned – and the standards have been the same since I've been in training – is that, essentially, if for some reason you do not wish to provide a service for a reason of conscience, you do not have to, but you do have to find a way to help that patient access that service, whether it is making a referral or whether it is providing a resource such that they will be able to access those services themselves. You know, generally speaking, physicians have been in a reasonably good equilibrium with that balance. As I said, I prefer the Ontario way of doing things, where you have to refer, because that puts the vulnerability of the patient at the core of what's going on here and puts the onus on the physician to find a way to deal with their own moral distress in these moments.

Ms Sigurdson: Right. It's their responsibility. Thank you.

The Chair: Thank you very much.

Member Glasgo, go ahead, please.

Ms Glasgo: Thank you, Mr. Chair, and thank you, Doctor, for being here today. I want to just start by saying that I respect that you hold the position that you do. When we are talking about conscience, we're talking about deeply held personal beliefs, and it's very obvious that you have deeply held personal beliefs, and I won't take those away from you. I won't even judge you for having them. I think it's totally reasonable for you to have them as well as practise in Alberta. I would just sort of start there.

I am concerned. I guess, just basic, my first question will be: do you have any problems with the current standard of practice in Alberta?

Dr. Ratti: Yeah. I've mentioned a few times that I would prefer an Ontario scenario here, but I'm willing to accept what we have in Alberta.

Ms Glasgo: Okay. Then my next question is fairly simple: do you think that doctors like the three that we heard prior to yourself, if

they had conscientious objections, should not be allowed to practise in the province of Alberta?

Dr. Ratti: No, I don't think that.

Ms Glasgo: Interesting. Thank you.

The Chair: Thank you.

We will now go to Member Pancholi. Go ahead.

Ms Pancholi: Thank you, Mr. Chair, and thank you, Dr. Ratti, for being here today and for your very eloquent and powerful presentation. I very much appreciate that. Given that you are somebody who works – you're an abortion provider. I'm sure that you have seen a lot with respect to attacks on reproductive rights, on health care rights for women in particular. I'm sure you're very aware of that. You spoke in your presentation very eloquently about perhaps the real motivations behind this bill and that it's being cloaked in conscience rights, where really it's actually potentially about something else. I'd like to know: given your experience and given your presentation today, what do you think the motivations behind the bill are?

Dr. Ratti: I think that the motivations of this bill are to have us in this room, sitting here talking about this, and I think that we are already fulfilling that. As I speak, I am talking about abortion rights in Alberta when we shouldn't be talking about abortion rights in Alberta. I think that this bill is motivated by antiabortion groups, some of which are likely foreign funded, funnily enough, and I think that this is a very political thing and it's a cynical thing and it is not about physicians. It is about reproductive rights, and it is about opening up a discussion about whether that makes sense again in Alberta.

The Chair: Follow-up, please?

Ms Pancholi: Yeah. Thank you. Following up on that, earlier there was a motion that was brought forward by members of the opposition about extending and making sure that women in rural areas in particular have access to reproductive health and abortion services, and that was actually voted down by government members. Does it seem like the rights of patients, particularly women seeking health care services – do you feel like it is being challenged? I think that even by your earlier comment, the fact that we're sitting here and talking about abortion rights when it is settled law – you know, do you think that there is really now a priority and this switch to talk about doctors is really about, again, minimizing and challenging pre-existing rights that women have to reproductive health?

Dr. Ratti: Yeah. I think it is a bait and switch, especially if there's not an appetite to actually support access to health care in rural Alberta for women in reproductive health. I mean, it's well known that conscience rights are used by antiabortion groups specifically and openly as a way to reopen this debate, so I can't sit here and talk like we are talking about doctors' consciences. We're not. This is a tactic.

The Chair: Thank you very much, Doctor.

Mr. Schow: Just quickly and just for clearing the record, this committee does not have the ability to kill any bill. We simply make recommendations as to whether a bill should move forward in the Chamber.

But to the question. From 1928 to 1972 Alberta had in place the Sexual Sterilization Act as government policy from the state. That

had doctors forcibly sterilize vulnerable people as part of a wider eugenics movement. This was considered normal and appropriate medical care and had substantial public support at the time. Let's flash back to 1949. Say that you were living then instead of 2019. Would you participate or refer forced sterilization?

7:40

Dr. Ratti: I resent the fact that you are comparing abortion to eugenics, and I won't answer your question.

Mr. Schow: Dr. Ratti, I did not compare abortion to eugenics. I'm simply asking you about a conscience matter here. I believe conscience is important. I believe you have every right to practise medicine as you do, and I support that right one hundred per cent. But the question is simply – it's about conscience rights and conscientious objections.

Dr. Ratti: You mentioned that you can't kill bills in this committee, but somehow this morning all the government members in this room managed to fire an electoral commissioner who's actively investigating . . . [interjections]

The Chair: Okay. Stop, everybody. Thank you.

We have six seconds left. We will not go back over given that there are only five seconds left.

Doctor, thank you so much for your presentation here today. Thank you for taking the time to be here.

We are now going to move on to our next item. That's the Trans Equality Society of Alberta. We can welcome them to the table, please. Next I would like to invite Stephanie Shostak and Holly Tomm from the Trans Equality Society of Alberta to join us at the table to provide their five-minute presentation, which is to be followed by up to 15 minutes of questions. Thank you very much. I see you're ready. The floor is yours. Thank you.

Trans Equality Society of Alberta

Ms Shostak: Thank you, Chairman Ellis, and to the rest of the community for allowing the Trans Equality Society of Alberta to address you this evening. TESA was founded 10 years ago to fight the abrupt delisting of gender reassignment surgery, or GRS, by the government. It saddens us that we have to be here today to fight once again for the rights of transgender Albertans for equal access to health care. TESA's mission is to be a witness and a voice for matters concerning trans Albertans. With that being said, when we reviewed this bill, we quickly determined that this would impact each and every Albertan.

Transgender and gender nonconforming people face rampant discrimination in health care settings, are regularly denied needed care, experience a range of health risks because they are transgender or gender nonconforming. The biggest barrier to health care reported by transgender individuals is the lack of access due to the lack of providers who are sufficiently knowledgeable on the topic of transgender health. Other barriers include financial barriers; lack of insurance or lack of income; lack of cultural competency by health care providers; health system barriers such as inappropriate electronic records, forms, lab references in clinical facilities; and socioeconomic barriers such as transportation, housing, and mental health. While some of these health care barriers are faced by other minority groups, many are unique and many are significantly magnified for transgender people.

The majority of the discussion on this bill has focused on physicians and religious health care organizations and how they would be able to exercise their ability to not provide health service

to Alberta based on their conscientious beliefs. This bill is broader than that. It impacts all health care providers in this province under the Health Professions Act, and there are 28 colleges.

This bill seeks to make one individual right absolute above all others. Conscientious rights are important, and they are already enshrined in Canadian law. However, the Canadian Charter of Rights and Freedoms, provincial human rights legislation, and courts recognize that no rights are absolute. No one right is more important than another right, and there is no hierarchy of protected grounds. When our rights as human beings come into conflict with each other's rights, we must always ask ourselves: where is the greater harm? We would like to ask you today: where does that greater harm lie? Does it cause more harm for a health care provider to provide timely and effective referral for a procedure that they have moral objections to, or is there a greater harm to deny a patient that timely and effective health care?

As this bill stands, the right of the patient to timely and effective health care can be denied without consequence, and it puts the conscientious rights of that health care provider above and beyond the rights of that patient. Section 7 of the bill would prohibit any patient from seeking civil, criminal, or human rights actions against the health care provider or religious health care organization. Once again, this would put one right as absolute over all others and would not allow any patient any recourse if they have not received timely and effective health services.

Then the bill continues to section 8, making changes to the Alberta Human Rights Act by embedding "conscientious beliefs" as protected grounds without debate on Alberta's most important law. This concept goes against the fundamental principle that our government is elected to represent all Albertans as equals under the law. Governments exist to provide parameters for everyday behaviour for all citizens, to protect them from outside interference, and to provide for their well-being. This addition is contrary to that. These conscientious rights would be applied to all areas – goods, services, accommodations, tenancy, employment practices, even membership in trade unions – and would impact every Albertan, especially those who are most vulnerable in our communities. This bill amounts to nothing more than legalized, government-sanctioned discrimination.

The Chair: Thank you very much, Stephanie, for that presentation.

We're going to move on to the next part of our program, which will be the 15-minute Q and A. We'll start with the Official Opposition. I see Member Irwin. Go ahead, please.

Member Irwin: Thank you. Thank you, Stephanie and Holly, for being here today. I know this is not easy. I try not to get emotional because I'm sure you've heard countless stories of folks in our community, in the LGBTQ2S-plus community, who are struggling already, and this is going to add so many more barriers to health care access.

You know, one of the things I appreciated in the submission you provided to all of us is that you noted the following:

Reproductive rights, gender identity, and terminal illness are not choices people make; beliefs and professional designation are.

We must be mindful that human rights such as healthcare apply to all, and that all are equal in their rights. Make no mistake, denying relevant medical treatment based on conscience rights will lead to meaningless deaths and suffering.

You also noted that the biggest barrier is lack of access due to lack of providers. Can you share some of the stories that you've heard related to lack of access?

Ms Tomm: There are so many of them. Lack of access to health care for transgender people is rampant in this province. It's a

problem everywhere. Whether it's rural, whether it's urban, we hear stories of patients being denied basic health care services. And we're not talking about services that are specific to transgender people. We're talking about having a broken leg. We're talking about going to a walk-in clinic saying, "I have a sore throat," or "I have an infection," and they say: "I'm sorry. We can't help you. We don't know trans medicine."

The Chair: Do you have a follow-up, Member?

Member Irwin: Well, I mean, I wanted to hear some personal stories, so thank you. I know you've heard countless . . .

The Chair: A follow-up?

Member Irwin: Yeah. I'll get to a follow-up question.

I mean, we know that this bill is unnecessary. It's not needed. We know that there's a lot of work that we need to do as well. What would you say to those doctors previous who talked about how trans health won't be affected by this bill and how they sort of dismissed those concerns?

Ms Tomm: I don't believe that at all. If this bill goes through, trans health will definitely be affected because this bill, the way it is written, gives any health care provider in this province the right to simply refuse service and walk away. As it stands now, any health care provider in this province can use that conscientious objection and not provide that service to me, but they are legally and morally obligated to provide me with the information and the referrals to get the services that I need.

7:50

The Chair: Thank you very much.

Mr. Schow: Thank you, both, very much for being here. Just to quickly talk a little bit about what you said, about whatever doctor had the audacity to say, "We don't know trans medicine for a sore throat," shame on them, absolutely. I think that's just totally inappropriate, and that doctor should be ashamed of themselves for saying something of that nature to someone looking for treatment of a sore throat or something of that nature.

We talked also, Stephanie, about conscience rights and how important they are, and I do believe that as well. You also mentioned that there is potential harm on both sides, and I can see where you're coming from there. We would like to get this right. I think that's part of this committee, to analyze how to get it right. My question to you is: do you have any suggestions or any thoughts about what might be a happy medium that balances conscience rights but also makes sure that those who need medical treatment are not denied such treatment?

Ms Shostak: My recommendation would be to recommend to the Legislature to kill this bill. It's not necessary. There are already processes in place, and they are working in this province.

The Chair: Do you have a follow-up, sir?

Mr. Schow: Well, I do just want to follow up. I know that, again, as I stated earlier, this committee does not have the ability to kill a bill. That is the purview of the Legislature itself. We simply make recommendations. I just want to say again that I appreciate you being here. I hope that we can find that happy medium.

The Chair: Okay. That was just a comment? All right.

Is there a comment that anybody would like to make?

Ms Tomm: No. I'm fine with that.

Ms Pancholi: Thank you, Ms Shostak, and thank you, Ms Tomm, for being here today and sharing your stories. I think you've actually been echoing what we've heard from some of the earlier stakeholders, surprisingly, in that what we have in our current system works and is that balance. I appreciate that you shouldn't have to try to fix a bill that is clearly flawed and that is clearly detrimental to patients and particularly vulnerable patients.

I just wanted to ask you, because I believe that both of you in your experiences can probably speak to an issue that we've been talking about here, but particularly for trans people in rural or remote areas I'm sure that you have come across – I mean, we know that the challenge in accessing health care for any trans person is that, a challenge. But, particularly, do you have stories of individuals from rural areas, even the process of that first approach with the doctor and how it may add an extra barrier and layer of challenge for those individuals to seek health care generally?

Ms Tomm: Okay. Rural Alberta, as has been said before here tonight, is challenging medically across the board. When we start talking about medical care for transgender people in rural communities, it becomes even more complex. When you have smaller centres where you have one physician or one pharmacist or one nurse and that physician has the ability to say, "Well, I'm sorry; I can't consciously do this, but I can give you a phone number; I can give you the information," at the very least there is hope. If we take away that referral, if we say to these people, "I'm sorry; I don't agree with who you are; I'm done" and walk away, we take away that hope.

As has been stated here again this evening, when we are in that position, we are vulnerable. We are scared. We don't know how to access the system. We're reaching out to the health care professionals because we need their help. We need the answers.

The Chair: Do you have a follow-up, Member?

Ms Pancholi: Yes. Thank you, Mr. Chair. Specifically, one of the things that Bill 207 does is that it extends their interpretation of conscience rights to a number of health professionals, not just doctors, not just nurses, extends it even to counsellors, therapists. I'm wondering if you can comment on the wide scope of the professionals which are captured within this bill and how that might directly affect the people that you work with the most.

Ms Tomm: The social workers, the therapists, the psychiatrists: those people are crucial. For a vast majority of the transgender community, for the LGBTQ2S-plus community, the first contact we have is a social worker. We go to the resource centres. We go to the pride centres. We reach out to Skipping Stone. They say: "Here's a name. Go to that social worker." That is a crucial contact for us. We need those people there, again, to provide us those supports, but if we reach out to those social agencies and we get a stone wall and no other referrals, no other information, we crawl back into our closets, and we start harming ourselves, because the system is not there to support us. This is where the danger of that bill lies.

The Chair: Mr. Neudorf, you're next.

Mr. Neudorf: Thank you, Mr. Chair. Thank you, both, very much for coming. I appreciate you sharing your perspectives and the challenges that you faced. It is our task as this committee to review legislation put before us and try our very best to understand the ramifications of it and understand how we can move forward in our role as legislators.

I'm very curious to get a little bit more feedback from you. Because we live in such a diverse community within Alberta, we do have an incredibly broad spectrum of beliefs across the board. I'm hoping that you might be able to provide some input and more perspective. If you have any thoughts on: how do we protect an individual's rights, no matter where they are on that spectrum, as well as not discriminate against someone else who would hold possibly a different perspective? As you can see, that's quite a challenge there, so I'm just asking if you have any thoughts or contributions to make in that regard.

Ms Tomm: As we stated in our opening statement, rights will always come into conflict. We always need to look at whose rights are going to be causing the greater harm if they're denied, right? We do believe that health care professionals should have the ability to access that conscientious right. We do believe that every Albertan is allowed to believe what they believe. So I would ask you again – and I hope this answers your question – where is the greater harm? Is there a greater harm in asking a health care professional to provide that referral, or is the greater harm denying that person access in a timely and effective manner to health care services?

Mr. Neudorf: Thank you very much.

The Chair: A follow-up, Mr. Neudorf?

Mr. Neudorf: No follow-up. Thank you.

The Chair: Thank you very much.

Ms Sigurdson: Thank you so much for being with us tonight. One of the things about the Health Professions Act: of the 28 regulated professions in that, they are self-regulating professions, right? So if there is a complaint that's put forward against you, then you are sort of investigated by your peers. You know, you may have to go before a tribunal or something like that. For me, it would be social workers, so we'd be around that table so people understand that practice. For nurses, it's nurses. There are 28 professions. There are a lot.

One of the fundamental things about being a self-regulated profession is that when a complaint is made from a client, a patient, whatever term we want to use, they can make a complaint to your college. That's part of being a professional, being responsible for your practice, following your code of ethics, standards of practice. This legislation as proposed says that for people who have a conscientious belief and don't want to provide a service because of that belief, if, say, yourselves or someone doesn't want to give me a service and I make a complaint, that would be immediately dismissed – immediately dismissed – by my college, which seems to fly in the face of fairness and things like that. I don't know. Just your comments about that

8:00

Ms Shostak: We look at the legislation, and we totally agree. The way the bill is written, it dismisses the complaint outright. A real concern there is: why are they making one right absolute over another right? There are so many other rights out there. If you look at the Charter, for whatever reason all of those rights are enshrined in the Charter, and no one right supersedes another right, so why is there this push to make conscientious rights the absolute over all other rights that we have in our society? We don't see that there's a reason for that, and law has already proven that no one right supersedes another right.

The Chair: You have a follow-up, Member?

Ms Tomm: I'd actually like to add . . .

The Chair: Go ahead. Yes. Absolutely.

Ms Tomm: . . . very quickly, if I may. Eliminating that complaint, dismissing that complaint automatically takes away something from the system that nobody has really touched on here. The doctors are human beings, health care providers are human beings, and they make mistakes. They may say, "This is against my conscientious right." If there's a complaint mechanism in process, the college can say, "You know what? No, you've got it wrong," so all of the other health care providers can read that ruling and say, "My understanding of this is flawed." But if we don't have that process, there's no way to learn from it. We stop. When we stop learning, when we stop growing as a society, we're in trouble.

The Chair: We have about 30 seconds left. I'm going to just ask our two guests if they'd like to make any final comments with less than 30 seconds left.

Ms Shostak: As board members and directors of the Trans Equality Society of Alberta trans rights are human rights. Limiting access of any citizen to timely and effective health care regardless of the reason affects us all.

Thank you.

The Chair: Great. Thank you. Holly and Stephanie, thank you so much for being here. I thank you for your presentation. I also thank you for the Q and A with, obviously, the committee members. Thank you very much.

Next we do have another guest, Dying With Dignity Canada. We have, I think, one guest here to attend at the table. We'll let him get set up. Finally, tonight I would like to invite Bradley Peter from Dying With Dignity Canada to join us at the table, to provide a five-minute presentation, which will be followed by up to 15 minutes of questions. Thank you, sir, for being here. The floor is yours when you are ready. You have five minutes. Thank you.

Dying with Dignity Canada

Mr. Peter: Thanks for having me. My name is Bradley Peter. I'm a director of Dying With Dignity Canada. I am also a leader of the organization's Edmonton chapter. Dying With Dignity Canada is a national human rights organization working to improve quality of dying in Canada and to defend end-of-life rights. One of our main objectives is to break down unfair barriers which exist to patients who are trying to exercise their right to medical aid in dying. Our organization believes very strongly that Bill 207 represents one of those barriers. We believe very strongly as well that access to medical aid in dying would be impeded under Bill 207.

When we look at balancing conscience rights versus individual rights to accessing health care, we insist that the weight of that burden not fall onto the most vulnerable person in that equation. People in Alberta who are accessing medical aid in dying are an average age of 71. They are dying of horrific conditions like metastatic cancers, MS, and ALS. It is unrealistic to expect that because we have a central care co-ordination system, now doctors don't even have to inform patients about end-of-life options, including medical aid in dying. It is outrageous to think that a central care co-ordination system makes up for that. The patients that I work with, that I meet with: these people can barely sit up. They can barely hold a pencil. Some of them cannot even open their eyes during our meetings. Some of them can't even speak. It is

unrealistic to expect of them to pick up a phone, to hop on a website, to send an e-mail when they're trying to access medical aid in dying without the support of a health care professional in that process.

Further, it is unconscionable to take away the right to make an effective complaint because in the case of medical aid in dying, if a patient is prevented from accessing medical aid in dying, the severity of that complaint is actually that someone has now died an unwanted, prolonged, and agonizing death. This is a very serious complaint. It is outrageous to suggest that, as the bill suggests, this would be dismissed outright.

Dying With Dignity also strongly condemns strengthening of any rules that would support forced transfers for medical aid in dying. A forced transfer occurs when an individual is in a nonparticipating, publicly funded health care institution and they are transferred out of that facility because that brick and mortar has been granted conscience rights not to support medical aid in dying. So now a patient is pushed out of a facility where maybe they've been in there long enough to consider that place their home. They're being pushed out of that place to die. Just over a year ago we learned of an instance where two individuals, both suffering from ALS, both in different health care institutions, were forced onto the street to access an assessment for medical aid in dying. We had someone go to the media saying that their loved one was assessed in a bus shelter.

This is the type of behaviour that takes place when we place the conscience rights of institutions above the rights of patients trying to access health care. It is shameful and heartbreaking that this is what patients are facing at the end of life and that Bill 207 seeks to reinforce the system that was in place that placed this burden onto these patients. I can't help but think that if Bill 207 had been in place when those patients were put out onto the street, individuals today still would be being assessed for medically assisted deaths in bus shelters.

I think you would actually find that most Albertans would agree with us. There was a 2019 Ipsos poll which revealed that actually 80 per cent of Albertans support the idea that all publicly funded health care institutions should provide access to medical aid in dying. Bill 207 really tramples on the rights of individuals trying to access that in health care, but it's also in complete opposition to the supermajority of Albertans, who would support medical aid in dying access in all publicly funded health care institutions.

On Monday a committee member asked – I'm sorry; I can't remember which member it was – if this bill was even addressing the actual gaps that exist in accessing medical aid in dying, and it doesn't. We should be looking at bills which seek to protect patients who are accessing medical aid in dying and not bills which seek to protect the practices that threaten to harm them.

Thank you.

The Chair: Thank you very much, sir, for your presentation.

Before we get to the 15-minute Q and A, I just want to remind all committee members, especially as many of you are new – and I certainly understand that, and this is not directed at any one person – that many of the rules of the Chamber do apply within the committee, so there is no tweeting or posting on social media while in the committee room. Those are the same rules that apply within the Chamber as well.

With that being said, I thank everybody. I thank you, sir, for the presentation.

We will now go to the Q and A, beginning with the Official Opposition. Member Pancholi, go ahead. Thank you very much.

Ms Pancholi: Thank you, Mr. Chair, and thank you, Mr. Peter. I think this is a very important element of the discussion that we have

not yet been able to fulsomely get into. I really appreciate your comments for the patients that you represent. Particularly when it comes to medical aid in dying, because of the more, I guess, recent nature of it with respect to the Supreme Court of Canada and the decision that now we're actually supporting it, I think that perhaps you maybe have a very good perspective on the particular barriers that are maybe even slower to come down because this is such a new experience for so many providers and for the health care system.

I really want to pick up on your comments about the institutions or organizations that are now being granted conscience rights under this bill because that's yet another, I think, very problematic element of this bill which we haven't yet been able to really talk about. I think that if you could just maybe flesh out a little bit more about maybe – when we think about conscience rights, we usually think about them being individually held personal beliefs. But, really, by expanding that, that really is now saying, “Who gets to make that decision?” I suppose. I imagine this is something you've given some thought to, and I would appreciate your thoughts further on that.

8:10

Mr. Peter: Conscience rights granted to publicly funded hospitals are already causing barriers to access. I met with a patient at the general hospital who was facing a forced transfer. She had been assessed and approved for medical aid in dying. She was now facing a forced transfer, so she would have to be taken out of her hospital room to die. She asked me if she should book a hotel room at the hotel across the street that she could see out of her hospital room window, and her biggest concern was how they would discreetly remove her body from the hotel. Again, this is the type of behaviour that exists when the conscience rights of an institution are placed above the conscience rights of Albertans. More so, I can't imagine the trauma for her care team, who maybe aren't conscientious objectors but the institution they're working in is. So now her entire care team or members of her care team have to watch her be transferred out of their care because their institution conscientiously objects. Where are the protections for conscientious supporters of medical aid in dying who are working in these institutions, and why does the bill not address that?

The Chair: A follow-up, Member?

Ms Pancholi: I don't, really. Yeah. Thank you. I think that's great.

The Chair: Thank you so much.

Mr. Sigurdson, go ahead, please, sir.

Mr. Sigurdson: Yeah. I just wanted to say thank you for coming in and sharing with us as well. Of course, this is a very sensitive issue, and definitely there has to be a healthy balance here; there really does. But I just wanted to kind of ask a forward question. I mean, right now, under the CPSA, do you agree with the CPSA as it stands? Just hypothetically, if the current way the CPSA is drawn up was, for example, legislated, would you agree with that? And then maybe your comments.

Mr. Peter: To my knowledge, Bill 207 doesn't try to legislate the CPSA's conscientious rules.

Mr. Sigurdson: That's not what I was asking, just so you understand. I was asking: just the way the CPSA is structured right now.

Mr. Peter: The way that it's written, it actually could be stronger. It could have a model where an effective referral is actually

required, where it's very explicit that an effective referral for MAID is required. So it could actually be strengthened.

Mr. Sigurdson: Okay. Excellent.

Thank you, Chair.

The Chair: Thank you very much.

We now have Member Irwin. Go ahead, please.

Member Irwin: Thank you, Mr. Chair, and thank you, Bradley, for being here today. As another member noted, it is sensitive and it's a hard topic, but it's important. We need to have these discussions, certainly, when rights are being potentially undermined here.

My apologies if you did touch on this in your opening remarks, but I don't believe you did. Could you walk us through what an effective referral would look like for medical aid in dying?

Mr. Peter: An effective referral is not the same as a direct referral. What we've been discussing tonight about effective referrals, I think, is rather misleading. An effective referral for MAID could be that a doctor asks an administrative person on their unit to make sure that that patient gets in touch with the care co-ordination system. So to suggest to me that physicians will be fleeing the province or that physicians will have to quit their jobs because they've asked an administrative person to get them in touch with the central care co-ordination system, honestly, I think that is fearmongering.

Member Irwin: Thank you.

The Chair: Thank you very much, Member.

We will now go to Mr. Horner. Go ahead, please, sir.

Mr. Horner: Well, thank you, Chair. Thank you for being with us, Mr. Peter. I was the committee member that, I think, you were referring to, speaking about the gaps in the bill.

Mr. Peter: Yes. Thank you. I'm sorry that I didn't remember.

Mr. Horner: No. No one would have. I was telling a story about being new to this role, and that was a scenario that played out for us. I'm very against limiting access to services in rural Alberta. I came here and ran in this role to do just the opposite, in fact, so I appreciate your comments there. Do you see a scenario, whether it was this bill or something completely different, where we could, without putting those two things at cross purposes to one another, strengthen these services in rural Alberta and provide supports to these physicians? I've heard a lot about rural Alberta in this room. I don't know if there are more physicians that feel this way in rural Alberta, but I definitely know that there are more gaps in health care in rural Alberta, so I just would like to hear your comments. Yeah. Go ahead.

Mr. Peter: Thank you. When we talk about rural Alberta, we have to acknowledge that there are entire communities in rural Alberta who are only served by Covenant hospitals, which have conscientious objections to medical aid in dying.

There are examples out of Nova Scotia where a health authority has approached an objecting hospital and said: listen, you need to at least provide a room in the hospital where individuals can access medical aid in dying. That would be a very simple solution to creating more access in rural Alberta. Again, I think, you know, as we heard from our last speaker, the burden that would exist on an institution in that scenario would be far outweighed by the burden that would exist on an individual experiencing enduring suffering at the end of life, who now can't access health care in the hospital.

The Chair: Okay. That's great. Thank you very much.
Member Sigurdson, go ahead, please.

Ms Sigurdson: Yes. Thank you. Thank you very much for your presentation. I wonder if you could just talk a little bit more – you did refer to it already, that the people that you are working with are extremely fragile. You say that they can't hold a pencil, that some of them can't sit up, you know, very weak, indeed. I know that certainly not everyone who does want medically assisted dying is accepted. Like, there are all sorts of criteria. I wonder if you could talk a little bit about that, just about what process is gone through in order for someone to be able to access these services.

Mr. Peter: What is the process for someone to get access to medical aid in dying? Is that the question?

Ms Sigurdson: Yes.

Mr. Peter: In Alberta there is a central care co-ordination system, which, I think, every single speaker tonight has praised as being a great system. There is an assessment process. You require two assessments from physicians; you're required to provide consent multiple times throughout the process; there's a 10-day waiting period; there are forms that require independent witnesses. Accessing medical aid in dying is already a lengthy process and very difficult, so to impose any additional barriers to access, to delay access to such an urgent and personal medical request is egregious. The process is already full of checks and balances.

Ms Sigurdson: Okay. Thank you.

The Chair: Thank you very much. We'll go to the government members' side. Does anybody have a further question?

Seeing none, I'll go back to the Official Opposition. Is there a further question? Mr. Nielsen, go ahead, sir.

Mr. Nielsen: Thank you, Mr. Chair. Thank you again for coming here this evening. I appreciate your insights. I just wanted to go back a little bit to when you were talking about some of the clients that find themselves in hospitals, their age, of course, being a concern. Have there been any cases where there are individuals that can't be moved from the facility once they arrive?

Mr. Peter: There was a really sad case out of B.C. I mean, you can essentially always move a person. Can you do that without causing harm? Probably not. There was a case in B.C. where an individual had to be taken off their pain meds for the ambulance ride to a different hospital, and their final moments were agonizing. So it's unfair to suggest that, oh, everyone can just easily find a different hospital. It's not that simple. Patients do not choose where they end up in hospital. Both of my grandparents died in Covenant facilities, and it is really sad to me to think that at the end of life, when they can barely sit up, when they can barely open their eyes, they would have to take an ambulance ride to a different facility.

I'm sorry if I didn't answer your question.

Mr. Nielsen: No. You did.

My follow-up question, then, Mr. Chair, would be: if there is an instance where individuals cannot be transferred for whatever those reasons could be and they're trying to access medical assistance, would that not then, if the facility exercises its conscientious rights, essentially be denying them access to a legal health service?

Mr. Peter: If a patient was unwilling to be transferred out of a facility because of fear of pain or something like this, then absolutely that is preventing someone from accessing medical aid in dying.

Mr. Nielsen: Thank you.

The Chair: Thank you very much.

Mr. Neudorf, go ahead, please, sir.

Mr. Neudorf: Thank you very much, Mr. Chair. Thank you, Mr. Peter, for being here. I don't want this to come out the wrong way at all. I'm just wondering about your professional background, just so that I understand the context in which you're providing answers. If I can ask that, please.

8:20

Mr. Peter: Yeah. I've worked on medical aid in dying issues since 2012, since before legislation was available. Actually, my background is as a biologist. The reason I got into this field is because in 2009 my grandmother died a prolonged and painful death because medical aid in dying was not available to her. So I'm here as a patient advocate.

Mr. Neudorf: Thank you. I do appreciate that. Thank you very much.

My follow-up question. In this role, as our health care system is progressing or evolving or whatever language we'd like to use with that, I'm just trying to understand. I know that doctors have in the past always taken the Hippocratic oath. I do not know if that's a requirement still to this day. I don't know if that becomes a challenge or a hurdle that you have to overcome in how doctors would approach that from a legal or a registration side, if you sort of get my question.

Mr. Peter: It's a great question. A Hippocratic oath is not a binding oath, for one. A Hippocratic oath is an ancient oath that is carried on by tradition. The original Hippocratic oath has been modified, so not every doctor says, "I will do no harm," and of course I think the most important piece here is that "do no harm" is available to interpretation. A doctor who believes that keeping a patient alive against their will, who is dying an agonizing death, would believe that that is doing harm, but actually providing that patient with medical aid in dying would be treating that patient's suffering. Do no harm: I think that to raise that as a spectre of preventing access to medical aid in dying is wrong on many fronts.

Mr. Neudorf: Thank you. I appreciate that.

The Chair: Thank you very much.

We'll go now to the Official Opposition. No further questions? Thank you.

Once again, I'll ask the government members. Nothing.

Sir, thank you so much for being here today. I really appreciate the presentation as well as the Q and A from our committee members.

Members of the committee, I am going to exercise the prerogative of the chair as we, of course, have had six presentations. Before we continue with our deliberations, we will take a five-minute break, okay? A five-minute break.

Mr. Nielsen: Seconded and thirded.

The Chair: Seconded and thirded.

All right. A five-minute break, and then we'll return.

[The committee adjourned from 8:22 p.m. to 8:28 p.m.]

The Chair: All right. Ladies and gentlemen and committee members, I'll ask that if there are other conversations, side conversations, that security help out and maybe they can step outside, or please take your seat. You're certainly welcome to take your seat. I see members of the Official Opposition, I see our government members, and we will proceed with the committee deliberations.

Now, before we start with committee deliberations, I just have to put on the record what was identified very, very recently by Parliamentary Counsel. I'm just going to read this into the record here. I've already talked with members of the Official Opposition, so it doesn't require any further discussion, but for the record, before we begin deliberations on Bill 205, I just want to note that it has recently been brought to my attention that there are some inconsistencies between this bill and the provisions in Bill 25, Red Tape Reduction Implementation Act, 2019. These provisions are being reviewed to determine whether the inconsistencies can be resolved. At this time, however, this is only for the committee's information, and the committee is not precluded from continuing its work.

Okay? Okay. Thank you very much.

Ladies and gentlemen, hon. members, turning now to the committee's deliberations on bills 205 and 207, I would remind members that pursuant to Standing Order 74.2(1) the committee must now consider whether these bills should proceed or not proceed and potentially offer other observations, opinions, or recommendations with respect to these bills. The committee's process allows for up to 60 minutes of deliberation on each bill although the committee may extend this time limit if there is consensus that additional time is necessary. Since our meeting is scheduled to end at 9 p.m., if the committee is unable to complete its deliberations by this time, there may be a need for at least one other meeting next week unless there is consensus that the committee would like to continue to sit past 9 o'clock tonight. Thank you very much.

Hon. members, at this time I will now open the floor to a discussion on the committee's recommendations with respect to Bill 205. Again, as we've previously discussed, this is a government member's bill, so we will start by opening discussion with members of the Official Opposition. That being said, we have a speakers list going on here, and if you would like to be on that speakers list, please get the attention of the clerk.

Mr. Nielsen, go ahead, please, sir.

Mr. Nielsen: Well, thank you, Mr. Chair. I guess, to first start off with, I would like to thank all of the presenters this evening for both Bill 205 and Bill 207. I appreciate all of the insight that they shared with us, and I think it'll help us to be able to make some decisions here tonight. But specifically around Bill 205, I certainly learned a lot this evening. I think there's work that Alberta is able to do to be able to move this kind of bill forward, and hopefully with what the committee heard this evening, there are potential insights and things that we can offer the government that would help to keep this going.

We've certainly heard that there have been attempts in the past around this kind of legislation, and they just kind of, I guess, stalled out, so hopefully we won't be in this kind of situation again with Bill 205. Once it does get back, you know, to the House, I would certainly recommend, I think, that we are able to deal with things like cultural sensitivities, looking at the indigenous perspective of how this could work for their community.

I would certainly urge members of this committee that we vote to have this bill proceed to the House.

The Chair: Okay. I will just say this. We'll ask if there's any government member that wants to say a few words. Yeah. Mr. Sigurdson, go ahead.

Mr. Sigurdson: If you don't mind. Just on behalf of the government I also want to thank everybody that came tonight and presented on behalf of both these bills. But I just wanted to say in regard to this bill, Bill 205, that I think it provides a really good,

solid foundation. I mean, we understand that there's more to be done, but I think there's a lot of strength within this. There was a common theme through the mandatory referral, quarterly reporting, and audit process. I think that's something that all the presenters said is really important moving forward. I think this is going to elevate the discussion. It's really going to help.

I can't speak on behalf of all of my colleagues, but I think that I personally really support this bill. I think it's going to have a good impact for all Albertans.

The Chair: What I'm hearing here is a broad consensus to bring this back to the Assembly. I see the nodding of heads. Okay. Hon. members, if I can get somebody to move the motion which is before us right now. All right.

Member Pancholi moved that

the Standing Committee on Private Bills and Private Members' Public Bills recommend that Bill 205, Human Tissue and Organ Donation (Presumed Consent) Amendment Act, 2019, proceed.

All in favour, say aye. Any opposed?

That motion is carried.

Okay. Next up, hon. members, we're going to move to Bill 207 – my apologies. Before we get to Bill 207, we have to direct research services to do the report, so let's just get that. We need somebody to move that. Okay. Mr. Neudorf. We'll add that, and we'll just get this put up on the screen here. All right.

Mr. Neudorf will move that

the Standing Committee on Private Bills and Private Members' Public Bills direct research services to prepare a draft report on the committee's review of Bill 205, Human Tissue and Organ Donation (Presumed Consent) Amendment Act, 2019, in accordance with the committee's recommendations and authorize the chair to approve the committee's final report to the Assembly on or before noon on Tuesday, November 26, 2019.

All in favour, say aye. Any opposed?

That motion is carried.

Okay. Now Bill 207. Hon. members, the committee may now consider whether Bill 207 should proceed or not proceed and potentially offer other observations, opinions, or recommendations with respect to this bill. I'll now open the floor to a discussion on the committee's recommendations with respect to Bill 207.

Again, this is a government bill, so we will now begin with the Official Opposition. I see Member Pancholi. Go ahead, please.

8:35

Ms Pancholi: Thank you, Mr. Chair. Based on what we've heard tonight from the stakeholders, there was actually – wait. I'm going to back up a little bit because there are a few things that I think we need to mention with respect to the process and the feedback that we've received with respect to Bill 207. I'm certain many of the members on this committee, including, I know, my colleagues – but I can say that, for myself, I've received an unprecedented amount of feedback from individuals with respect to Bill 207. While I will admit that there are certainly some that are in favour of it, it's actually very difficult to identify which of those are actually constituents of mine or even residents of Alberta, but primarily I've received an enormous amount of correspondence opposed to Bill 207.

While, of course, we know that this is a divisive issue and there are a lot of very strongly held beliefs, perhaps, on both sides, I think what has become very clear through the process that we've taken this bill through so far within this committee is that this bill is fundamentally flawed and that it does not seem to be in a form or in any way ready to move forward. I say that because, first of all, the very member who brought this bill forward, on the very first day he presented it, brought it in with a significant number of

proposed amendments, which speaks to the very fact that the member is already of the view that the bill in its current form is not ready to go forward, that it's got significant issues. Unfortunately, for the member, he did not seek any consultation or input prior to bringing this private member's bill forward. But he, by his own admission, I think, has indicated that the bill in its current form is flawed.

To that end, we also had a number of stakeholders brought in who are not even from Alberta, and in fact what we consistently heard through the stakeholders that presented in support of the bill was that what we currently have in Alberta is actually working great. In fact, I believe the one member said that it's a dream, that it's exactly what they would want in Ontario. So there does not seem to be an identified problem that needs to be fixed.

Clearly, based on the input we've received from the stakeholders today, there may be a problem in Ontario, but that's not what we're here to do. We're here to legislate and to speak to Albertans and to represent Albertans. What we consistently heard from all stakeholders was that we currently have a standard of practice in place from the College of Physicians & Surgeons of Alberta that governs physicians and how they may conscientiously object and that it does still require them to balance their conscientious objection with their patients. I think we heard very compelling arguments and positions from many stakeholders about the vulnerability of particular patients and that, really, in that power imbalance situation we should – and it is our obligation as lawmakers and legislators – look out for the most vulnerable Albertans.

I also might add that, simply with respect to process in this committee, we did have a commitment from the sponsor of the bill to provide a legal opinion that he relied upon to speak to the constitutionality. I made repeated requests for that opinion because the member assured us that he would provide it. I had asked for that opinion to be provided before this committee met again. I made repeated requests for that. It was not provided until after our committee hearing began today.

I also note that we indicated at the last committee meeting that we would accept written submissions. I understand from the clerk that there were up to 400, but this meeting was scheduled to start 15 minutes after the deadline for written submissions to be provided, and I still do not see those written submissions on the committee website. Even if they were there now, I was not able to review those submissions prior to this meeting today. I certainly don't think any other members were able to read those submissions.

Simply, with respect to the process that's taken place so far, we have not been able to hear from enough people. We certainly can see from the sponsor's comments and who he brought in as stakeholders to support it that he did not speak to enough people, certainly not enough Albertans, certainly not enough vulnerable Albertans, and really the consistent message is that the current practice, the standard of practice from the College of Physicians & Surgeons balances the conscience rights of doctors and providers with their patients.

I might add that what we've repeatedly heard from stakeholders today was that it was necessary, potentially, to pass Bill 207 so that we could legally protect the rights that are already set out in that standard of practice. But it should be noted that in order for a standard of practice by the College of Physicians & Surgeons to be changed, the risk – they kept stating that the risk was that it would be changed and that somehow the conscience rights would be undermined. Well, in order for those rights to be changed, the Minister of Health has to approve those rights.

Government still has an oversight over that matter, so to suggest that we need a bill such as Bill 207 to enshrine something that is

already set out, that is already working, that is far broader – let's be very clear. The bill that was presented in this committee is far broader than what is set out in that standard of practice. It extends to 28 health professionals. It denies them the right to even make a complaint to their professional bodies should somebody refuse to provide services on the basis of conscience.

This bill is not about balancing rights. It's about protecting one individual group's right and completely denying the rights of the most vulnerable patients in this province. In my view, it is absolutely clear that this bill is flawed, that it is not in a position to move forward, that it is not even supported. Even the stakeholders that came in today to support the bill could not support it in the form that it was presented by the member.

I do not think this bill is in a position to proceed, and that is how I will be moving forward on this.

The Chair: Thank you very much, Member.

The clerk informs me that all of the submissions are under the submissions link. That's what the clerk informs me, but your points are certainly well taken regarding the 15 minutes. There are a lot of submissions there, so certainly thank you for that comment.

We will now move to Mr. Schow. Okay. Go ahead, sir.

Mr. Schow: Thank you, Mr. Chair. Also, I just want to express my gratitude to all the stakeholders who presented tonight. It is obviously not easy to come sit at a table in front of a bunch of elected officials and present your case. Regardless of what side you came from, I'm genuinely grateful for the time that you've taken and also to those in the gallery who've taken the time to be here to witness this. Certainly, I believe and you believe that this is important enough to be here, so thank you.

I also believe in conscience rights. I genuinely believe in that, and I believe that we need to find a happy balance between making sure that the adequate and world-class care in medicine that we have here in this province is maintained for everybody. But I also recognize that caregivers also have a role to play in respecting their own conscience, and I don't believe that people should be required to check their conscience at the door when they leave the house to go to work, and that's in any line of work.

With that said, I do believe that there is some division on this bill as to whether or not to support it, and that's not our job to debate tonight. It's whether or not it should go to the Chamber, whether it should be debated there by Members of the Legislative Assembly. Like Member Pancholi, I have received probably more correspondence on this than anything in my short time in office. I believe my constituency assistant said today that it was above 600 letters to my office, and I would be doing them a disservice if I didn't get a chance to debate this.

I believe that this should go forward towards the floor of the Chamber so that other members as well can debate this on its merits as it is, and I think that that's what this committee's job is to do, to put it forward or to decide not to put it forward. My belief is that it should go forward to be deliberated by the members so they can act on their own conscience and also use their vote to respond to their constituents and their correspondence.

The Chair: Okay. Do we have a member of the Official Opposition? Member Irwin. Yeah. Go ahead, please.

Member Irwin: Yeah. I mean, I'll be quick, because any time I follow my colleague from Edmonton-Whitemud, I'm in awe, so I can't say a whole lot more other than to echo her comments that this bill is fundamentally flawed. The process from the beginning was rushed as well, I felt. You know, we'd asked for additional stakeholders. Like Member Schow, I received a whole heck of a

lot of correspondence on this, and the reality is that we've heard from a lot of people across this province. We've heard from hundreds of doctors, some of whom are in the crowd, and it's unnecessary.

You know, this same committee – let me just talk about the fact that, for the people in the gallery who've not been here before, we have traditionally voted to move bills forward out of the private members' committee because we felt that private members have an opportunity to present bills and to move them to the House. In this case, this has been fundamentally flawed, and I'd like to also point out that when my colleague the hon. Member for Edmonton-Rutherford presented a bill on public health care, the UCP members of this committee said that it was unnecessary and said that it shouldn't proceed, okay? I would hope they use the same logic this evening – right? – when we've heard from even their own stakeholders who have implied that it's unnecessary, that it's not needed.

8:45

So I urge the members opposite to think about that, think about what their constituents are saying, think about what Albertans are saying, think about the fact that in our last meeting it was clear from the member that he couldn't name whom he had consulted with. He didn't provide a list of the doctors he had consulted with. He was only able to have one doctor who's currently practising in the province of Alberta present this evening. We could have had dozens of doctors present, but unfortunately we were only allowed to have one.

For me, this is about fundamental human rights. I'm trying to not get emotional, but I'm on five hours of sleep. This is about fundamental human rights, and the rights of so many Albertans are at risk with Bill 207.

The Chair: Thank you, Member.

Member Glasgo, go ahead, please.

Ms Glasgo: Thank you, Mr. Chair. I want to start by saying that I understand that this is a very emotional topic, that there are a myriad of ways that one can approach something like this. I understand that there are many people around this table who have felt conflicted and perhaps have lost sleep over this, you know, or felt as though there's a delicate balance between your own personal conscience and what your constituents are saying. When I ran in my nomination and in the general election, I ran on my very clearly articulated personal beliefs. Those were validated by my constituents. I have received in excess of 500 e-mails in support of Bill 207. I have received fewer than 50 in opposition to Bill 207. Whether you want to like that or not, that's simply the fact.

I personally believe that we are stronger because we can have our own conscience rights, that we can conscientiously object, that we can speak on matters of personal conscience ourselves. I will be voting with my conscience on this, which means that I will be voting for it to proceed. My views have been very clearly articulated, and they align with my constituents'. I believe that the spirit of this bill needs to be pushed forward to the Chamber so that the Chamber can have the final say.

The Chair: Member Sigurdson, go ahead, please.

Ms Sigurdson: Yeah. Thank you very much, Mr. Chair. There are sort of, I think, three key things that stand out for me in this legislation that I have concerns about, like other members on the opposition side. It's clear that there were some second thoughts because of the amendment sheet that did come, that, of course, we couldn't receive until we were in the House. There are some

shortcomings that are pretty profound, and I think that, you know, many of the presenters today did articulate them very well.

One is just the extremely broad definition of conscientious beliefs. That definition isn't even anywhere in any kind of legislation all across our country. Like, there is kind of, you know, no precedent for that. I mean, that right away makes me think that we should go back to the drawing board on this bill and that it shouldn't go forward.

Another aspect is that, certainly, I just always want to remember – I mean, I know we've heard from many doctors – that this is actually governing 28 professions. It's not just doctors. The ramifications, the implications of that: I don't know if that's all been thought out. You know, I brought it up before – and I'll bring it up again – that my background is social work. Always such a fundamental piece of being a social worker is that you're – it's a responsibility of mine as a social worker to manage that conflict between my personal and my professional values to ensure that my client is supported. That's just sort of fundamental, so to have not even a referral required is unethical. So I can't understand and I certainly can't support legislation that would not require that.

Then the third piece is just the immediate dismissal of the complaint. You know, I worked at the College of Social Workers for 10 years before I was elected. I have a lot of pride in my profession. But just like every other profession, social workers make mistakes, and some of them are pretty big.

I just think that this legislation should not go through. These are just too large, too tremendous shortcomings of it.

Thank you.

The Chair: Thank you.

Mr. Sigurdson: I'm just going to start by saying as well that I think five hours of sleep is probably twice as much as I got last night.

I want to say that I come from a family that dealt with the health care industry. My mom was a nurse for decades. My dad was a paramedic as well. I've really had to deeply think about this one a lot. I've been conflicted. I've been back and forth. But, really, what was said earlier tonight is something that I know my mom has always lived by. She's a Christian – I'm a Christian – and she always believed that you have to make sure that when you're getting into this, you're balancing religious beliefs and conscience beliefs. You have to look at what's going to do the most harm.

As a legislator and with the fact that we are looking at a bill right now that is flawed – it is flawed – in my opinion, the way that the bill stands right now, it will do harm. I cannot guarantee nor can any of us guarantee that any amendments will come to this bill. As it stands right now, looking at this bill, I cannot support it. I cannot support this bill moving forward for those reasons, so I just want to be vocal in the fact that I will not be recommending this bill go to the floor as it stands right now.

The Chair: Any comments over here? Go ahead, Mr. Nielsen.

Mr. Nielsen: Comments to his or of my own?

The Chair: Of your own. Yes, of course, your own.

Mr. Nielsen: Right. Thank you, Mr. Chair.

The Chair: It's been a long day.

Mr. Nielsen: Yes, it has been a very, very long day, and we've had to take in a lot of information in a very, very short period of time.

As I mentioned earlier, my background is in labour. I get hung up on language. I'm always looking for how language can

disadvantage people, how language can be misinterpreted, how language can work against people. So the bill as presented: I'm seeing situations. I think Ms Sigurdson had mentioned this around the complaints. We cannot have a system that doesn't allow us to make complaints, because the regulatory bodies that as lawmakers we have allowed to be put into place – these were groups that said: we have the ability to regulate ourselves; we have the ability to work with our professionals when they make those mistakes. When we as legislators start to interfere in that, we also now have to start asking: well, then, why do we need them? So are we really ultimately moving towards, you know, getting rid of these things and taking all of this back? I don't think that's productive, and certainly these professional colleges would highly disagree with something like that.

You know, again, getting hung up on the language around the word "may" – of course, we've had a big debate on that throughout last night and today – at this point in time it's very, very ambiguous. When I've heard stories where individuals can't access services that they are allowed to access, that means that by creating those situations as legislators, we are blocking them. We very, very clearly heard that we want people to be able to access services that courts have decided they are allowed to access.

Currently the way this bill is structured, I think we as a committee have a duty to make our decision, based on what we see right now, which is a flawed bill in its language. I think, Mr. Sigurdson, you had said that we can't presuppose whether an amendment will come forward or not, in what form it will come forward or not. So I think it makes it very, very difficult for the committee to be able to move forward.

8:55

The Chair: Thank you very much, sir.

Hon. members, at this point it's about 5 to 9. We have probably just under 35 minutes left in deliberations on this bill. I'm going to ask for unanimous consent of this committee to go past 9 o'clock. I will pose the question to the committee. All those in favour, say aye. Any opposed?

Unanimous consent has been granted.

We will now go on to Mr. Nixon. Go ahead, sir.

Mr. Jeremy Nixon: Thank you very much. I want to make sure it's on the record that I am a firm, firm, firm supporter of conscience rights and will always do my best to defend that as a legislator. I think it's an absolutely critical and fundamental part of our society, and that's why it's held within our Charter of Rights nationally. But I'm also a firm supporter of nondiscriminatory practice and open access to health care. We cannot in the process of protecting someone's rights trample over the rights of another.

I understand what Bill 207 is attempting to do. I don't believe that it has insidious or hidden intentions, but something with as sweeping a scope as what is being proposed in this bill opens the door for many unintended consequences. That, quite frankly, is the reason why I will be voting against this bill. I don't believe this bill is equipped to deal with those unintended consequences.

The Chair: Okay. Thank you very much, sir.

Is there anybody from the Official Opposition that would like to go next? No?

Mr. Neudorf, go ahead, sir.

Mr. Neudorf: Thank you. There's a little bit of a preamble here, for the multitudes of people obviously watching this on television at home, but I just feel it helps me process how I view everything that we do here. As members of the Private Bills and Private Members' Public Bills Committee it's our task to review each bill,

seek input from stakeholders, and make a recommendation for a bill to proceed, which is concurrence, or for a bill not to proceed. Either way, the members of the Assembly will have at least one hour to debate and then vote on accepting or not accepting the recommendation of this committee.

There are theories that promote the idea that every private member's bill should pass, but then why have a committee? Or there's the idea that only government private members' bills pass and that opposition private members' bills don't, and that should not be the case. In order for neither of these scenarios to take place, it requires significant independent consideration and judgment presented by each member of this committee, and I thank them for their efforts to do that. There is no prescribed decision-making matrix, no marking guide, no rules of evaluation for us to follow, and it's not necessarily based on our constituencies, as would be the case in the House. A vote here may be different than one's vote in the House because of that. Therefore, the burden lies on each committee member to review the bill, contemplate the impact and consequences not only on their own constituency but on all of Alberta and its population.

In reviewing Bill 207, Conscience Rights (Health Care Providers) Protection Act, I have considered the following factors: the voice of health care workers and their request for this type of legislation; the platform and priorities I ran on personally and under the United Conservative Party platform; the timing and context of our current public affairs, attitudes, and acceptance and the response of our Alberta population; the need presented to protect our private religious freedoms in the context of a fully accessible public health care system; and the importance of limiting the continuous growth of the state, bureaucracy, costs, and additional legislation unless it be clearly, thoroughly, and competently written.

In light of these guiding questions and the absolute belief in representing the people of Alberta to the best of my ability, after deep and considerable thought and deliberation it is my vote to not recommend the acceptance of this bill in its current form.

The Chair: All right. Thank you, sir, for those words.

I know there's one member who hasn't made any remarks as of yet. No? Okay.

Mr. Horner, would you like to go?

Mr. Horner: Sure.

The Chair: Go ahead.

Mr. Horner: Yeah. This has been quite a process. I've learned a lot in the last few days going through this. My e-mails are in the thousands, and a great many on both sides, you know. I don't want to make light of either of the feelings. We're talking about people's rights in both cases. I think that MLA Sigurdson said it very well, speaking about his mother in the health care system and how she believed: do no harm. I think that as legislators that should be our goal as well.

While I feel that there may be a bill out there that can provide security and relief for these workers in health care, I'm not prepared to recommend this bill to the floor because of what I foresee as some great consequence. Like it's been said, we already have major problems in our health care system regarding access, and I don't want to make that worse in this House today.

I do believe that it was a well-intentioned bill, but I won't be able to recommend it to the House.

The Chair: Okay. Thank you for your words, sir.

That being said, I know that it's obviously past 9 and that we've talked about this. I will ask committee members: does anybody

have any further comments that they would like to say? Member Irwin, go ahead.

Member Irwin: Yeah. I'd like to move the motion.

The Chair: Oh, sure. Yeah. Absolutely.

I just want to be clear that discussion has stopped as far as deliberation. Okay. Thank you very much.

Member Irwin would like to move that the Standing Committee on Private Bills and Private Members' Public Bills recommend that Bill 207, Conscience Rights (Health Care Providers) Protection Act, not proceed.

Does anybody want to have further discussion on this?

Member Irwin: I'd like to ask for a recorded vote.

The Chair: Sure. We have to have the voice vote first.

Member Irwin: Okay. Thank you.

The Chair: Is there any further discussion on this? Everybody is shaking their head. Okay. All right.

We'll pose the question first. All those in favour, say aye. All those opposed, say no. Okay.

Mr. Nielsen: A recorded vote, please, Chair.

The Chair: Thank you very much. A recorded vote. I will now read the procedure for recorded votes.

Hon. members of the committee, I would remind committee members that the standing orders now permit members to abstain from voting. With this change to the standing orders, during a recorded vote I will ask members in the room who are in favour of the motion to raise their hands, and then I will state for the record the names of all those in favour. Then I will ask those in the room who are against the motion to raise their hands, and I will state their names. In accordance with standing orders the minutes of the meeting will show the names of those who are for the motion and those who are against but not the names of those who abstained.

For the record I will just say that that motion was passed on the verbal vote, and then we've asked for this.

All those in favour of the motion as moved by Member Irwin, please raise your hand. We'll start to my right. For the record we have Mr. Neudorf, Mr. Sigurdson, Mr. Horner, Mr. Nixon, Member Sigurdson, Member Irwin, Member Pancholi, and Member Nielsen.

All those against the motion as moved by the hon. Member Irwin, please raise your hand. Mr. Schow and Member Glasgo.

Mr. Clerk, the vote has been recorded. Thank you very much. We will now go to the motion for research.

Dr. Massolin: You have to announce the results of the vote.

9:05

The Chair: Oh, sorry. My apologies. The results of the vote. For the record

it was 8 for and 2 against.

Thank you very much.

Okay. Hon. members, with the committee having finished its deliberations on Bill 207, the committee should now consider directing research services to prepare a draft report, including the committee's recommendations. Would a member wish to move a motion to direct research services to prepare the committee's draft report? Mr. Sigurdson. Let's get this on the screen here.

Okay. Mr. Sigurdson moves that

the Standing Committee on Private Bills and Private Members' Public Bills direct research services to prepare a draft report on the committee's review of Bill 207, Conscience Rights (Health Care Providers) Protection Act, in accordance with the committee's recommendations and authorize the chair to approve the committee's final report to the Assembly on or before noon on Tuesday, November 26, 2019.

All those in favour, say aye. Any opposed?

Hearing none. Thank you.

That motion is carried.

Other business. Are there any other issues for discussion before we wrap up today's meeting?

Seeing and hearing none, the date of the next meeting will be determined on whether a bill is going to ever hit the floor within the next few weeks, okay? If the committee is finished all deliberations, then the next meeting will be at the call, of course, of the chair whenever another private member's or public bill is introduced.

I will ask for a motion to adjourn.

Mr. Nielsen: So moved.

The Chair: Mr. Nielsen. Thank you very much, sir. All those in favour, say aye. Any opposed? All right.

Thank you so much. Have a great night, everybody.

[The committee adjourned at 9:07 p.m.]

