Second Session - Thirty-Ninth Legislature

of the

Legislative Assembly of Manitoba

Standing Committee
on
Social and Economic Development

Chairperson
Ms. Erna Braun
Constituency of Rossmere

Vol. LX No. 1 - 7 p.m., Monday, April 28, 2008

ISSN 1708-6698

MANITOBA LEGISLATIVE ASSEMBLY
Thirty-Ninth Legislature

Member	Constituency	Political Affiliation
ALLAN, Nancy, Hon.	St. Vital	N.D.P.
ALTEMEYER, Rob	Wolseley	N.D.P.
ASHTON, Steve, Hon.	Thompson	N.D.P.
BJORNSON, Peter, Hon.	Gimli	N.D.P.
BLADY, Sharon	Kirkfield Park	N.D.P.
BOROTSIK, Rick	Brandon West	P.C.
BRAUN, Erna	Rossmere	N.D.P.
BRICK, Marilyn	St. Norbert	N.D.P.
BRIESE, Stuart	Ste. Rose	P.C.
CALDWELL, Drew	Brandon East	N.D.P.
CHOMIAK, Dave, Hon.	Kildonan	N.D.P.
CULLEN, Cliff	Turtle Mountain	P.C.
DERKACH, Leonard	Russell	P.C.
DEWAR, Gregory	Selkirk	N.D.P.
DOER, Gary, Hon.	Concordia	N.D.P.
DRIEDGER, Myrna	Charleswood	P.C.
DYCK, Peter	Pembina	P.C.
EICHLER, Ralph	Lakeside	P.C.
FAURSCHOU, David	Portage la Prairie	P.C.
GERRARD, Jon, Hon.	River Heights	Lib.
GOERTZEN, Kelvin	Steinbach	P.C.
GRAYDON, Cliff	Emerson	P.C.
HAWRANIK, Gerald	Lac du Bonnet	P.C.
HICKES, George, Hon.	Point Douglas	N.D.P.
HOWARD, Jennifer	Fort Rouge	N.D.P.
IRVIN-ROSS, Kerri, Hon.	Fort Garry	N.D.P.
JENNISSEN, Gerard	Flin Flon	N.D.P.
JHA, Bidhu	Radisson	N.D.P.
KORZENIOWSKI, Bonnie	St. James	N.D.P.
LAMOUREUX, Kevin	Inkster	Lib.
LATHLIN, Oscar, Hon.	The Pas	N.D.P.
LEMIEUX, Ron, Hon.	La Verendrye	N.D.P.
MACKINTOSH, Gord, Hon.	St. Johns	N.D.P.
MAGUIRE, Larry	Arthur-Virden	P.C.
MALOWAY, Jim	Elmwood	N.D.P.
MARCELINO, Flor	Wellington	N.D.P.
MARTINDALE, Doug	Burrows	N.D.P.
McFADYEN, Hugh	Fort Whyte	P.C.
McGIFFORD, Diane, Hon.	Lord Roberts	N.D.P.
MELNICK, Christine, Hon.	Riel	N.D.P.
MITCHELSON, Bonnie	River East	P.C.
NEVAKSHONOFF, Tom	Interlake	N.D.P.
OSWALD, Theresa, Hon.	Seine River	N.D.P.
PEDERSEN, Blaine	Carman	P.C.
REID, Daryl	Transcona	N.D.P.
ROBINSON, Eric, Hon.	Rupertsland	N.D.P.
RONDEAU, Jim, Hon.	Assiniboia	N.D.P.
ROWAT, Leanne	Minnedosa	P.C.
SARAN, Mohinder	The Maples	N.D.P.
SCHULER, Ron	Springfield	P.C.
SELBY, Erin	Southdale	N.D.P.
SELINGER, Greg, Hon.	St. Boniface	N.D.P.
STEFANSON, Heather	Tuxedo	P.C.
STRUTHERS, Stan, Hon.	Dauphin-Roblin	N.D.P.
SWAN, Andrew, Hon.	Minto	N.D.P.
TAILLIEU, Mavis	Morris	P.C.
WOWCHUK, Rosann, Hon.	Swan River	N.D.P.

LEGISLATIVE ASSEMBLY OF MANITOBA

THE STANDING COMMITTEE ON SOCIAL AND ECONOMIC DEVELOPMENT

Monday, April 28, 2008

TIME – 7 p.m.

LOCATION – Winnipeg, Manitoba

CHAIRPERSON – Ms. Erna Braun (Rossmere)

VICE-CHAIRPERSON – Ms. Bonnie Korzeniowski (St. James)

ATTENDANCE – 11 QUORUM – 6

Members of the Committee present:

Hon. Mses. Melnick, Oswald, Hon. Mr. Selinger

Ms. Braun, Mr. Cullen, Mrs. Driedger, Messrs. Faurschou, Goertzen, Ms. Korzeniowski, Mr. Nevakshonoff, Ms. Selby

APPEARING:

Mr. Kevin Lamoureux, MLA for Inkster

WITNESSES:

Bill 8–The Phosphorus Reduction Act (Water Protection Act Amended)

Mr. Darren Praznik, Canadian Cosmetic Toiletry and Fragrance Association

Mr. James Beddome, Private Citizen

Mr. Paul Walsh, Private Citizen

Bill 11–The Optometry Amendment Act

Mr. David Cochrane, O.D., Manitoba Association of Optometrists

Bill 18–The Testing of Bodily Fluids and Disclosure Act

Mr. Keith Atkinson, Manitoba Association of Chiefs of Police

Ms. Jodi Possia, Paramedic Association of Manitoba

Mr. Alex Forrest, United Fire Fighters of Winnipeg

Mr. Mike Sutherland, Winnipeg Police Association

Mr. Ken Mandzuik, Manitoba Association for Rights and Liberties

WRITTEN SUBMISSIONS:

Bill 18–The Testing of Bodily Fluids and Disclosure Act

Mr. Richard Elliott, Canadian HIV/AIDS Legal Network

MATTERS UNDER CONSIDERATION:

Bill 8–The Phosphorus Reduction Act (Water Protection Act Amended)

Bill 9–The Protection for Persons in Care Amendment Act

Bill 11–The Optometry Amendment Act

Bill 12–The Securities Transfer Act

Bill 18–The Testing of Bodily Fluids and Disclosure Act

*** * ***

Madam Chairperson: Good evening. Will the Standing Committee on Social and Economic Development please come to order.

For the information of everyone in attendance this evening, we may have some lights and cameras set up in the room tonight. This is because the Legislative Assembly Media Services will be filming part of tonight's proceedings for inclusion in the video *Standing Committees of the Legislative Assembly of Manitoba*.

This meeting has been called to consider the following bills: Bill 8, The Phosphorus Reduction Act (Water Protection Act Amended); Bill 9, The Protection for Persons in Care Amendment Act; Bill 11, The Optometry Amendment Act; Bill 12, The Securities Transfer Act; Bill 18, The Testing of Bodily Fluids and Disclosure Act.

We have a number of presenters registered to speak this evening as follows:

For Bill 8, we have: Darren Praznik representing the Canadian Cosmetic Toiletry and Fragrance Association; James Beddome, private citizen; Paul Walsh, Dollar Wise Quality Cleaners.

For Bill 11, we have: David Cochrane, Manitoba Association of Optometrists.

For Bill 18, The Testing of Bodily Fluids and Disclosure Act, we have: Jodi Possia, Paramedic Association of Manitoba; Alex Forrest, United Fire Fighters of Winnipeg; Mike Sutherland, President of the Winnipeg Police Association; Keith Atkinson, Manitoba Association of Chiefs of Police; Ken Mandzuik, Manitoba Association for Rights and Liberties.

Before we proceed with presentations, we do have a number of other items and points of information to consider. First of all, if there is anyone else in the audience who would like to make a presentation this evening, please register with staff at the entrance of the room.

Also, for the information of all presenters, while written versions of presentations are not required, if you are going to accompany your presentation with written materials, we ask that you provide 20 copies. If you need help with photocopying, please ask our staff.

As well, I would like to inform presenters that, in accordance with our rules, a time limit of 10 minutes has been allotted for presentations, with another five minutes allowed for questions from committee members.

Also, in accordance with our rules, if a presenter is not in attendance when their name is called, they will be dropped to the bottom of the list. If the presenter is not in attendance when their name is called a second time, they will be removed from the presenters' list.

A written submission on Bill 18 from Richard Elliott from the Canadian HIV/AIDS Legal Network has been received and distributed to committee members. Does the committee agree to have this document appear in the *Hansard* transcript of this meeting? *[Agreed]*

Order of presentations: on the topic of determining the order of public presentations, I will note that we do have out-of-town presenters in attendance marked with an asterisk on the list. With this consideration in mind, in what order does the committee wish to hear the presentations?

Mr. Tom Nevakshonoff (Interlake): Madam Chairperson, given that the outside presenters have been identified on the list, I would suggest that we would hear from them first for their convenience.

Madam Chairperson: Is that agreed? *[Agreed]*

I would like to inform all in attendance of the provisions in our rules regarding the hour of adjournment. Except by unanimous consent, a standing committee meeting to consider a bill in the evening must not sit past midnight to hear presentations, unless fewer than 20 presenters are registered to speak to all bills being considered when the committee commences. As of 7 o'clock this evening, there were nine persons registered to speak to these bills, therefore, according to our rules, this committee may sit past midnight to hear presentations. How late does the committee wish to sit tonight?

Mr. Nevakshonoff: Well, Madam Chair, I suggest we sit until midnight if necessary and if we're still here at that point in time, then maybe we can revisit this issue.

Madam Chairperson: Okay, the will of the committee? *[Agreed]*

Prior to proceeding with public presentations, I would like to advise members of the public regarding the process for speaking in committee. The proceedings of our meetings are recorded in order to provide a verbatim transcript. Each time someone wishes to speak, whether it be an MLA or a presenter, I first have to say the person's name. This is a signal for the *Hansard* recorder to turn the mikes on and off.

Thank you for your patience and we will now proceed with the public presentations.

Bill 8–The Phosphorus Reduction Act (Water Protection Act Amended)

Madam Chairperson: Darren Praznik, Canadian Cosmetic, Toiletry and Fragrance Association.

Mr. Darren Praznik (Canadian Cosmetic, Toiletry and Fragrance Association): Thank you, and I have copies, Madam Chair.

Madam Chairperson: Thank you. Please proceed.

Mr. Praznik: Thank you much, Madam Chair. I must admit it's somewhat different being on this end of the table, but certainly a pleasurable one.

Madam Chairperson, Madam Minister, ministers, former colleagues and members of the Legislature, thank you very much for the opportunity to make this presentation to you this evening on behalf of the Canadian Cosmetic, Toiletry and Fragrance Association, which I have the honour of

representing. The CCTFA was founded in 1928 and is really the voice of the personal care products industry in Canada. We represent some 160 companies which represents the bulk of the industry in terms of product and it counts for some $5.4 billion a year in annual sales. I also have another, I guess, personal interest. Being a Manitoban always at heart, I still have a home on Lake Winnipeg, so I appreciate this particular bill and what it's trying to do.

***** (19:10)

First of all, let me say that our association believes very strongly in environmental stewardship. I'm not going to read from the presentation directly. It's there, so it captures the essence of our message. I would just like to speak to it tonight. But our industry is very firmly committed to strong environmental stewardship. We work very closely with the federal government now in the chemicals' management plan, which I think if you look at that particular plan, we've had batch one of chemicals come out earlier in the year. We have batch two coming out in mid-May. It really leads the world.

Canada, at this particular point on this issue at this point in time, has been the leader in the world. We work regularly with other associations and regulators in Europe and the United States. Although Europe is close, the actions that Canada's now undertaking have placed us really in the forefront of the world. We work very closely with the federal government who is leading the world in many of these particular areas on environmental regulation with respect to chemicals that our industry uses. Why we are in fact here today is not to take issue with the specific bill. I want to thank the minister and her staff who were very generous in giving us some time late last year to discuss the bill. We understand very fully the intent of why the minister's trying to bring forward this legislation. I must admit, if I were still in a ministerial office today, I don't think I would have taken necessarily a different approach. I understand that, and I understand what Manitoba was attempting to do.

Our problem is one more of general principle. We across the country are becoming more concerned along with other associations in the consumer product industries about provincial legislation with respect to ingredient content and labelling of consumer products. The problem with that is a very simple one. These particular products rely on economies of scale for production. When we have different regulatory regimes in provinces, it makes it very, very difficult to serve those markets. If provincial governments start regulating with respect to the content of individual consumer products, start regulating with respect to the labelling, and we've seen some private members' bills in Ontario and British Columbia in the last year or so that would suggest provincial labelling schemes on various consumer packaged goods.

What it creates are 13 potential different jurisdictions within an already small market of Canada with 30 million people. The difficulty with being able to meet those different regulatory regimes on consumer products becomes just an endless nightmare for anyone trying to bring product to the marketplace in Canada. We have seen more and more incursions into this area with each passing year and it is becoming a growing concern. Industries like ours are truly international industries. A plant that may produce a particular make-up, an eye colour, for example, I think of the MAC factory in Toronto that produces certain MAC make-ups. They produce on a world mandate. So we look for kind of regulatory oversight that allows us to meet the highest standard but in a uniform way. If we have various provincial governments in an already small market called Canada, attempting to introduce various regulatory regimes on our ingredients or labelling, it makes it just that much more difficult. I can tell you often what would happen, particularly if you are looking at a small market like Manitoba with less than a million people, it just becomes uneconomical to be in the marketplace.

So the main point that we wanted to make tonight at this committee hearing is that as a matter of principle we oppose provincial intrusion into the regulation at the provincial level on these particular matters. Now, having said that and having had the opportunity to meet with the minister, I have to be very complimentary because I think that was fully recognized, the circumstances in which the minister was forced to bring this legislation were very clear and very compelling. I also want to put on the record tonight the commitment of the minister that she made to work with our industry in any regulations that may or may not happen. But if they do, to work with us to make sure that Manitoba is not out of line with what is happening in the rest of the country.

So in those circumstances, I must say, we're very pleased with that commitment. We certainly will take the minister up on it if and when that time arises. But the general principle is one that we

wanted to ensure was part of this debate, part of this discussion, at least so that it's not forgotten and it's on the record. I will say this as well. We've seen other intrusions or legislative initiatives in a couple of other provinces that were not thoughtful at all, hadn't taken into account national regulatory schemes and did not show the foresight that I think this minister has shown in bringing forth this bill in the way it's been done. Quite frankly, should this bill pass the Legislature, we would be using this as an example of at least the thoughtfulness that should go into those occasions when a province does feel compelled to put pressure on the federal government.

But the bottom line is, the principle, which I think the minister has recognized in her comments to us, that Canadians are best served, both as consumers, as industry, both from a safety and environmental point of view, when these types of products that are mass market products that require large volumes for the economy of production, we are best served when the national government fulfils its mandate to properly regulate those products for health and safety and environmental reasons. That's what we support as an association, and that's what we continue to work with the federal government on.

To take it one step further in terms of personal care products, we are currently working with regulators and trade associations in the European union, the United States, and Japan on what's called the international cosmetic co-ordination of regulation process; what a mouthful. But it is a process that is designed to share the best of science on an international basis as we address nanotechnology and other new things that are facing us, and to try to align our regulatory regimes at least to process, so that we are able to have the–science is the same wherever you are. Getting it right and getting it in a manner that is easy to fulfill in products that traverse borders very easily is, I think, very key to accommodate trade.

I would just tell you, not only do our members import product for sale in Canada, but we do have members who produce product in Canada for export, and it's with international mandates in those facilities. The ability of those companies to be able to deal internationally with the same requirements and labelling is also important.

So, again, science-based regulation, which I think the minister's been fully supportive of, effective and efficient regulation, is a principle which should come from the national government is where we think we should be.

I would like to thank the minister for her efforts. I would also like to thank the two opposition critics who also met with us late last year for their interest in this particular matter.

Thank you for your time and your attention.

Madam Chairperson: Thank you for your presentation.

Do members of the committee have questions for the presenter?

Mr. Cliff Cullen (Turtle Mountain): Thank you, Mr. Praznik, for your presentation.

I certainly appreciate your concerns about having the potential of 13 different levels of legislation moving forward across the province. I think we may have issue with similar legislation coming forward from the government in terms of greenhouse gases as well.

You're probably aware of, and my understanding is, the federal government is moving forward with legislation as well in this regard. I'm wondering if you have a sense of the timing in terms of when the federal legislation might move forward, and, second of all, if you think the parameters or the levels within the federal legislation will be reflective of what's in this legislation here in Manitoba.

Mr. Praznik: First of all, I can't speak for Minister Baird or the federal government. We all watched the announcement that was made with respect to phosphates, and I think the kind of pressure building helped that to happen. You know, at the end of the day, Canadians elect all governments, provincially and federally, and they expect their elected members to be able to work together to resolve issues. Now, living in Ontario, I can tell you, that isn't always the case, the battles that rage there.

But one also has to appreciate that the federal government has it's agenda and it's attention span, and I certainly appreciate when a province like Manitoba, on an issue like phosphates in Lake Winnipeg–two years ago, I was home when the water was green like paint, so I understand the imperative–has to kind of shake the tree to get some attention. That was the case when I served in ministerial office, and it is still there. So my recommendation to any provincial government in Manitoba is to keep at it and, I think, to work co-operatively.

What impressed me about this legislation was it created, in essence, the stick, but it was one that didn't have to be used if the feds acted. I think the same should be true any time the provincial government is using its legislative power to poke the federal government along. If they do the right thing and you get a national consensus, it's always better to be part of that national consensus if you can get it, when you're regulating things on a national scale.

Madam Chairperson: Seeing no further questions, thank you, Mr. Praznik.

Mr. Praznik: Thank you, and nice to be home.

***** (19:20)

Bill 11–The Optometry Amendment Act

Madam Chairperson: I will now call on David Cochrane, Manitoba Association of Optometrists.

Thank you. Please proceed with your presentation.

Mr. David Cochrane (Manitoba Association of Optometrists): Madam Chairperson, ministers, members of the committee, it is truly my pleasure and my privilege this evening to present to the Standing Committee on Social and Economic Development as president of the Manitoba Association of Optometrists.

To introduce myself, my name is David Cochrane. I am an optometrist. I live and practice in Virden, Manitoba.

I would just like to spend a few minutes this evening speaking in support of Bill 11, The Optometry Amendment Act. I can speak on behalf of our entire membership in saying that the Manitoba Association of Optometrists is very pleased to be in support of this amendment to the current optometry act.

As a measure of that support, I might add that, when I stood up, I believe, there are 18 optometrists in the room for me, standing in support of this legislation.

I would like to take this opportunity to demonstrate that Bill 11 will allow optometrists in Manitoba to practice to the full potential of their training and education as has been demonstrated by the regulatory and statutory amendments that have occurred elsewhere in Canada as well as in the United States.

Manitoba's optometrists have known for years that we are an under-utilized resource of the health-care system in this province. The ability for optometrists to treat certain eye conditions would alleviate some of the pressures that are unnecessarily placed on busy medical family practitioners, emergency room physicians, walk-in clinics, ophthalmologists, in addition to our mutual patients due to the unnecessary travel costs, delays in treatments, potential for lost work and general inconvenience.

There are currently 107 optometrists practising in the province of Manitoba. Manitoba's optometrists are located geographically throughout the province, and not only in our major cities. We have members who live and work in nearly all major communities in the southern part of the province as well as the major northern communities.

Optometrists also provide itinerate services to many northern communities that are only accessible by air. Our rural and northern optometrists, especially, experience the difficulties involved in arranging for the treatment and management of eye conditions when access to ophthalmology services is only available on a regular basis in Winnipeg and Brandon.

Manitoba's doctors of optometry provide over two-thirds of the primary vision-care services to Manitobans. The current optometry act mandates that optometrists are required to diagnose all forms of eye disease and injury. However, optometrists are restricted from administering or prescribing any therapeutic drugs to treat these problems. Instead, patients must be referred to a physician or an ophthalmologist for treatment. This is, truly, no longer the case elsewhere in Canada and the United States. Optometrists have proven that they are capable of competently treating certain eye conditions by their long history of doing so in other jurisdictions.

At this time, if I can draw your attention to appendix 1 in my handout, TPA legislation in Canada. I probably used the word "TPA" a few times, and that just really stands for therapeutic pharmaceutical agents. Optometrists are somewhat unique in that abbreviation, because we've had to make the designation between diagnostic pharma-ceuticals and therapeutic pharmaceuticals. We often talk with that abbreviation where most medical practitioners don't, but my handouts will have that, and I will use that terminology.

If you look at this, you'll see that, for TPA legislation in Canada, this graphically demonstrates that at the current time only Manitoba, British Columbia and Prince Edward Island currently lack the enabling legislation to allow for the TPA privileges for optometrists in Canada.

I would also present for information appendix 2. I'm not going to read through it, but it's just a summary of the TPA legislation in Canada, the timelines. It shows the time line of other provinces when they have enacted the legislations. Even on the first page, you can see or you will notice that Alberta, New Brunswick and Saskatchewan have all had prescribing authority for optometrists for a minimum of 10 years.

As further background, I have included appendix 3, which is the optometric prescriptive authority time line in the United States. I have included this time line for American colleagues. It demonstrates the first U.S. TPA bill was passed in 1976, with the vast majority of states granting TPA privileges through the 1980s and '90s.

I've also included appendix 4, which is the scope of practice enactments – time line, which illustrates to you the number of times that TPA legislation for optometrists have been amplified in the United States. What I found of note in this document, which was provided to us by the American Optometric Association in St. Louis, Missouri, is the statement at the very last page that says: "Laws establishing or expanding prescriptive or treatment authority for optometrists have been enacted 171 times in the 50 states, the District of Columbia, Guam and Puerto Rico." Moreover, "Laws repealing or diminishing prescriptive or treatment authority for optometrists have never been enacted."

I would now like to take the opportunity as well to outline the level of prescriptive authority that is currently legislated in Canada and the United States.

I understand that there was some question, even in the House last week, as to what is currently allowed or provided for in other jurisdictions. So for that purpose I provided Appendix 5, which is a summary of the legend drug prescriptive authority for optometrists in Canada, which breaks down, essentially, topical pharmaceuticals that would be used in eye care amongst the different provinces, as you can see. Appendix 5A is a more descriptive breakdown of that and for your information.

Finally, appendix 6, you'll see that it is a subjective ranking provided by the American association for you, which is a summary of the legend drug prescriptive authority for optometrists. It is provided for you as an outline of the TPA prescriptive authority in the U.S. jurisdictions for your comparison. There's quite a bit of information there, but you will see that every jurisdiction in North America, except for Manitoba, Prince Edward Island and British Columbia, has this authority to some degree.

As evidenced by the information I provided to you in appendixes 5 and 6, optometrists of Manitoba are not currently able to provide the same level of eye-care services to Manitobans that Canadians in other jurisdictions have come to expect, that optometrists in other jurisdictions have proven they are capable of providing. The optometrists of Manitoba, however, are very pleased that the current Health minister is taking the opportunity to correct the situation. We are of the opinion that Bill 11 is well written, and it will provide a framer for regulations that will serve Manitobans and our profession for a long time to come.

We are, therefore, hopeful for the speedy passage of Bill 11 to allow for the development of the appropriate regulations, which will ultimately define the specifics of TPA practice of prescriptive authority for Manitoba optometrists. We are confident that the proposed expanded scope of practice will allow Manitoba optometrists the ability to better serve the eye-care needs of all Manitobans throughout the entire province. We are also confident the act amendment will provide for a new level of efficiency and quality in the delivery of eye-care services in Manitoba. At this time, we look forward to the next steps in the process, the passage of Bill 11, the establishment of the regulatory advisory committee, and the ultimate definitions of what will ultimately be the details of the prescriptive authority for Manitoba's optometrists. We look forward to, and we are committed to, working with medicine, pharmacy and government to attain that goal.

I thank you for your attention this evening. Thank you again for the opportunity to speak to your committee, and we would like to thank again the minister for bringing this bill forward.

Madam Chairperson: Thank you for your presentation.

Do members of the committee have any questions?

Mr. Kelvin Goertzen (Steinbach): Madam Chairperson, more a comment than a question. I want to thank you, Mr. Cochrane, for your presentation, for your colleagues who have joined you here this evening.

You certainly implored us to move quickly on this legislation. I know it's been some time in coming as we catch up across Canada. My colleague for Charleswood, also my colleague for Arthur-Virden, your members of the Legislature have been strong advocates over the last couple of years in trying to get this legislation to move forward, and I appreciate the work that they have done. Government and the Legislature, more generally, doesn't always work as quickly as we would like it to. I am glad that we are catching up with other jurisdictions in Canada. You can certainly rest assured that you have our support in moving this legislation quickly because we believe not only in your organization but in the skills that you have, and that you deserve to have the prescribing authority and the benefit it will have for the health care system overall.

Mr. Cochrane: Thank you.

Hon. Theresa Oswald (Minister of Health): Thank you very much.

Just a comment, Madam Chairperson. I wanted to thank you for being an out-of-town presenter and being in town for it. I want to say thank-you to your colleagues that are present this evening, not only for their presence but for the good counsel that you have offered us in the construction of this bill, and for the willingness and openness and collegial tone that you've taken in approaching this bill, and the days ahead, when we have an advisory committee, and we also have the regulatory development.

I have every confidence that this is going to be a very smooth process and a very, very good thing for the people of Manitoba who need to see their optometrists and get more help.

So thank you very much for your efforts this evening, and ongoing.

***** (19:30)

Mr. Cochrane: Thank you.

Again, I'd just like to say that the number of optometrists in presence is just really a show of how strongly we all feel about this legislation. We've been working for this for a long time. The original optometry act will be celebrating a hundred years this next year. We think it's fitting if the legislation were passed for our 100th anniversary.

We're very committed to the process. We understand the process, and we look forward to fulfilling the process.

Mr. David Faurschou (Portage la Prairie): I just wanted to ask, in regard to this bill coming into force, based upon a fixed date for a proclamation, in your deliberations with the minister, were there particular deliberations that would delay this bill's coming into effect?

Mr. Cochrane: Really, the passage of Bill 11, you know, I don't see there's any reason that it would have to be delayed.

I've said this before to the minister at a meeting, but it's really the details of the regulations that are important to us. We can't really move on to that step and work with medicine and government to develop the regulations until the act is passed, and the regulations, of course, as you know, can't come into effect until the act is passed. So our goal and our hope is just to have the bill passed as quickly as possible.

Madam Chairperson: Seeing no further questions, thank you, Dr. Cochrane.

Bill 18–The Testing of Bodily Fluids and Disclosure Act

Madam Chairperson: I will now call on Keith Atkinson, Manitoba Association of Chiefs of Police. Do you have a written presentation?

Mr. Keith Atkinson (Manitoba Association of Chiefs of Police): I do.

Madam Chairperson: Please proceed with your presentation.

Mr. Atkinson: Madam Chair, ministers, committee members, my name is Keith Atkinson. I'm the Chief of Police for the Brandon Police Service, and also the president of the Manitoba Association of Chiefs of Police, and I'd like to thank you for providing me the opportunity to speak here tonight.

The Manitoba Association of Chiefs of Police is comprised of chiefs of police and senior officers of most Manitoba police services and the Royal Canadian Mounted Police. The objective of the association is to encourage and develop the co-operation of its members as a management association for the purpose of leading the development of policing in Manitoba and

representing police leadership to the people, the Minister of Justice, and the government of Manitoba.

On behalf of the Manitoba Association of Chiefs of Police, I'd like to thank the government of Manitoba for introducing The Testing of Bodily Fluids and Disclosure Act. We believe this act will provide peace of mind to police officers who are exposed to blood and other bodily fluids. It is very common for police officers to be exposed to blood or other bodily fluids at scenes of violent crime or injury, traffic collisions, or being the victim of assaultive behaviour, where the perpetrator flings blood or spits at a police officer.

While police officers are well-informed of the risks of exposure to bodily fluids and are provided with equipment such as Kevlar gloves and latex gloves to protect them, as well as receiving vaccinations for hepatitis A and B, often they are forced to respond to emergency situations without having the opportunity to properly don their protective equipment, or the bodily fluid lands in the police officer's eyes or mouth. Although we recognize that the tests obtained at any time may not be 100 percent conclusive, it is at times like these that the police officer can take some comfort in knowing whether the source individual has a communicable disease.

At the same time, we recognize the need for treatment must continue, as some diseases may not be detectable at the time of the sample. In order to provide you with an insight of a police officer who has been exposed to bodily fluids, I'd like to read you a testimonial from a young constable who recently went through a relevant experience.

In the early morning hours of the night shift of December 2007, while effecting an arrest, I was spit in the face by an accused. There was a mixture of blood and saliva that hit my face as well as the inside of my mouth.

After taking the accused to jail, I immediately attended to the emergency room at a hospital where a social worker was contacted and conducted an interview with me. Later that night I was contacted by the social worker who advised me the accused has declined to consent to providing a sample of his blood and for me to re-attend the emergency room to begin treatment as the accused was a high risk for HIV or hepatitis C.

Emergency room staff performed an initial blood test on me, and I began treatment with the prescription Combiver–and I apologize for not pronouncing that properly, probably.

This was to be a 30-day prescription; however, after a week, I consulted with the public health nurse, and, due to constantly being sick, unable to eat, as well as difficulty drinking water or juice and other potential side effects, I made the determination to stop taking the medication. I was advised to re-attend for follow-up tests in about three to six months. The follow-up tests were performed in April 2008 and came back normal.

During this time frame it was very stressful for me as well as my family. All precautions had to be taken affecting marital relations as well as our lifestyle. Most personal items had to be kept separate from the rest of my family. Any lacerations I received had to be dealt with very carefully. My five-year-old daughter who normally helped with Band-Aids, however, instead had to be told to stay away, not understanding why.

From the date of the incident until the date of the follow-up results, this incident was on my mind, keeping me awake many nights. This incident could have been far less stressful if a sample of the accused's blood could have been obtained.

That was from a constable that provided that information.

As I'm sure you're aware, the police officer's job is a stressful one, in this particular case, causing stress on the officer's family as well. By enacting The Testing of Bodily Fluids and Disclosures Act, you can help alleviate some of the stresses that affect police officers in the province and add peace of mind to those officers that are exposed to blood or bodily fluids.

Thank you for taking time to hear me this evening.

Madam Chairperson: Thank you for your presentation.

Are there any members of the committee who have questions for the presenter?

Mr. Kelvin Goertzen (Steinbach): A comment, Chief Atkinson. Thank you very much for coming in. I know you are very busy. All the police officers of Manitoba at their various levels have a lot of work to do, and so we appreciate the fact that you've come to the Legislature to advocate on behalf of this legislation.

Certainly, I know over the last couple of years when we've debated private members' legislation, similar legislation with the same goal in mind here in the Legislature, I've had the opportunity to hear from some of your members in your detachment, but really members across Manitoba who've expressed to me often less for their own concern and more for their family. That's probably not an uncommon sentiment for the kind of people who are police officers in this province, that they're more concerned about others than themselves.

So I'm glad that we've reached this point. It's taken a little time, but I'm glad we've reached this point. We'll be supporting the legislation to ensure that peace of mind for their officers and their families is in place as quickly as possible.

Mr. Atkinson: Thank you.

Hon. Theresa Oswald (Minister of Health): Thank you very much for being here this evening.

I'll be brief. I know we've had an opportunity to speak in the past, and I appreciate the many efforts that you've brought forward on behalf of all those that you represent. I also know that you share with government the importance of us being able to achieve that balance of providing that peace of mind for the individuals that go out there every day and do things that many of us wouldn't dream of doing, taking care of their peace of mind, at the same time ensuring that we all work together on that education piece about what really active and aggressive things we can be doing in the area of protection and prevention and, in those cases, of severe exposure, encouraging our members to take that medication, uncomfortable as it's going to be. I know that we'll all be able to work together to get that message out so that, just as you rightly say, family members need not be harmed.

So thanks again for being here.

Mr. Atkinson: Thank you for those comments.

Mr. Cliff Cullen (Turtle Mountain): Thank you very much, Chief Atkinson, for coming in from Brandon to give your report.

It certainly hits home, the personal issues that front-line people are facing in Manitoba. I do want to commend the Member for Steinbach, very modest tonight, but he has brought forward this concept on a couple of occasions to the Legislature, and nice to see the Minister of Health (Ms. Oswald) has picked up on that novel idea.

The one issue that may be a little contentious is in terms of looking after the rights of individuals. I know that that is addressed in this bill, and I'm wondering if you've looked at that and if you're comfortable with the level of protection that is afforded individual persons and their rights.

***** (19:40)

Mr. Atkinson: Well, there are always going to be people that are detracting for this bill, but, you know, I put it this way: If a reasonable person, for instance, when you give blood, at Canadian Blood Services, you know there's a series of questions that you're asked and you go through them and make sure that you may not be a high-risk person. I mean, even if people would co-operate that way, but we know it's not a perfect world and we know that there are people out there that do not want to co-operate and will not disclose any type of information. I think this bill helps in that regard.

You know, there are times, obviously, when people at emergency services are exposed to blood, and people co-operate and they tell them whether or not they have any communicable diseases. But this protects the officer in those cases where a person refuses to do that.

Madam Chairperson: Seeing no further questions, thank you for your presentation.

Bill 8–The Phosphorus Reduction Act (Water Protection Act Amended)

Madam Chairperson: I will now call on James Beddome, private citizen. Do you have written comments?

Mr. James Beddome (Private Citizen): I have handouts here to distribute. Thank you very much.

Ladies, gentlemen.

Madam Chairperson: One moment.

Mr. Beddome: My apologies.

Madam Chairperson: You may proceed.

Mr. Beddome: Ladies, gentlemen, members of the Legislature, and distinguished guests, I just firstly would like to thank you for allowing me to present here today as an individual citizen. I am speaking here today on Bill 8, also known as The Phosphorus Reduction Act. Now this act is good in principle in that it does address a small portion of the problem leading to the eutrophication of our waterways, but the reason I'm here today is that I believe a more

comprehensive strategy is needed to seriously reduce the nutrient loads that are flowing into our waterways.

Now I think first we need to recognize that the vast majority of phosphorus is not coming from household waste water. If you look at the Lake Winnipeg Stewardship Board estimates, more than half of the phosphorus, 53 percent to be exact, that ends up in Lake Winnipeg flows into the province from other jurisdictions. The remainder represents Manitoba's share, of which 32 percent is caused by run-off from agricultural lands and 19 percent is from waste-water sources. Clearly, then, a comprehensive strategy would examine the other causes of phosphorus loading. But, for brevity's sake, and because Bill 8 only focusses on the household waste-water issue, regulating the phosphorus content in cleaning and personal care products, I will keep my focus refined.

Now, when looking at reducing the flow of phosphorus from households, I think it's first important that we identify where the phosphorus is coming from. The chart below that I've attached right here, and you can see, is coming from a publication called *Water, Science and Technology* and it's a study that was conducted at the Technical University of Hamburg-Harburg in Germany. So what we can see from this study is we can see that the vast majority of the volume is grey water, also known as wash water. But, when we actually look at the nutrient concentrations inside of that, we can see that about 10 percent of the phosphorus is coming from wash water. In contrast, if we look at human urine that's about 50 percent of the phosphorus and feces is about 40 percent of the phosphorus.

So, basically, what that means is that this bill is dealing with one-tenth of the problem. Obviously, I'm here today hoping that maybe this committee would consider addressing the other nine-tenths of the problem.

You know, there's even a certain amount of futility in regulating the phosphorus in grey water so long as we're going to continue to mix it with our black water or our feces and urine, the reason being is that it's ultimately mixed and it has to be dealt with when it reaches the waste-water treatment plant. I think the answer here that we need to be recognizing is that we need to be segregating urine, feces, and wash water at source.

Now, it should be acknowledged that all three levels of government have committed considerable sums of money to upgrading waste-water infrastructure in this province to remove nutrients and to cease the flow of untreated effluent into our waterways. Additionally, there have also been new licences issued that require that nutrient removal is obtained at large waste-water treatment facilities, and the government's presently undertaking investigations with numerous different groups as to how we might deal with smaller treatment plants such as constructed wetlands.

However, I would argue that we're asking the wrong questions. The question we're asking is, how do we remove nutrients from waste water, but what we need to be asking is: How do we stop creating waste water in the first place? Or, how do we stop putting these nutrients into our water? To this end, I would direct the government to look at the Lake Winnipeg Stewardship Board's recommendations 20.1 and 11.2.

Now, recommendation 20.1 speaks about the importance of supporting innovative and emerging technologies. The latter half of 11.2 identifies source control pollution prevention plans as measures to reduce nutrient input. Keeping grey water, urine and feces segregated from each other and sanitizing them at source, as close to source as possible, is the best way that we can deal with treatment. Basically, what that does is it keeps the bulk of the nutrients from entering the sewage system in the first place.

Grey water, when not mixed with black water, has a relatively low nutrient and pathogen content. It therefore can be treated and reused even for drinking water through relatively simple procedures such as sand filtering or constructed wetlands.

Feces contain the bulk of the majority of pathogens and also the highest concentration of nutrients, but, if we compost our feces and if we obtain thermophilic decomposition, which is above 55 degrees Celsius, the pathogens will be sanitized and the nutrients containing the feces will be returned to the soil. These have been proven to meet both the EPA and the German state regulations.

Now, urine is generally sterile, except for a few exceptions and, given its high ammonia, nitrogen, phosphorus and potassium content, it has the potential to serve as a alternative to conventional synthetic fertilizers. It is worth noting that the skyrocketing price of fertilizers here, and, if there are any farmers out here, I'm sure they are well aware of that.

Also, using the aforementioned chart that I provided here, we can sort of take a look at, and we can see, that 50 percent of the phosphorus is coming from urine. Therefore, if we diverted the urine alone, we would obtain five times the reduction of phosphorus coming from households that this bill is going to obtain.

Just to sort of crunch the numbers a little bit, if every Manitoban was diverting their urine, that would be over 400,000 kilograms of phosphorus, over 4.6 million kilograms of nitrogen, and 1.14 million kilograms of potassium that would not be entering into our waterways.

So why, then, do we use water to dispose of our excreta? Is mixing one litre of urine with 13.2 litres of water a good use of our precious water resources? I would obviously argue that I don't think it is. The fundamental flaw with our current approach to dealing with human urine and feces is that we mix it with water in the first place.

The truth of the matter is that we really only use water as a means of transporting our excreta. Roughly 80 percent of the cost of conventional sewer systems is on the collection of the sewage or the transportation or the sewage, whereas only 20 percent is spent on the treatment. By segregating our excreta and treating it at source, we can achieve simultaneous reductions in cost and nutrient inflows into our waterways.

As already mentioned, most jurisdictions in the province are in the process of upgrading our sewage facilities. The Manitoba government has promised $206 million for the city of Winnipeg and $150 million for rural municipalities. Now, when undertaking investments of this kind, I think it is vital that we ask ourselves, is this the most judicious use of our expenditures? The $206 million for Winnipeg is part of a $1.8-billion, 10-year plan that will see the city upgrade its sewage infrastructure and waste-water treatment plant. That works out to just under $2,800 on a per capita basis. So, once again, we need to be asking ourselves, are there not alternative ways of sanitizing bodily excrements? The answer I would say is yes.

When it comes down to it, the most efficient method for dealing with or treating excreta from all living systems is humus-laden, aerated, biologically active soil. An example of this type of environment would be the leafy floor of a forest. Now, of course, most of us live in urban centres. For us, access to this type of natural ecosystem does not exist. However, technology does exist that mimics the natural processes that aerobically break down organic matter into extremely valuable resources: humus, nutrient-rich topsoil or soil conditioner. This is referred to as the process of ecological sanitation. I would ask this committee and the members of the public to check out www.ecosanres.org for more information.

Now, the idea of ecological sanitation is that human excreta is treated, segregated at or near source with minimal use of water, if any is used at all. A composting toilet is the most typical method for breaking down excreta into nutrient-rich topsoil. As the name suggests, these toilets collect excreta and compost it, rendering the end product not only safe to handle but also a valuable agricultural resource. Composting toilets are practical and efficient and affordable. They have proven themselves at Queen's University Botanical Garden, the Bronx Zoo. We have two located here in Winnipeg at Mountain Equipment Co-op and the Centre for Indigenous Environmental Research in the Kay Building.

***** (19:50)

Now, on the lower end of the price spectrum, we can sort of see that there are different models. One of them is the Canadian-made Sun-Mar composting toilet. It retails for around $1,400. Of course, all these ones have different features. Some segregate urine, some treat urine and feces together. Some used a couple of ounces of water per flush. Regardless, they deal with it. Another example would be the Clivis Multrum variety. That's what we have here in Winnipeg. It's one of the oldest and most highly-regarded composting toilet companies in the world. Their base-line model starts just under $3,000 U.S., just more than we are spending on a per capita basis here in Winnipeg.

In a conversation with one of their sales staff, I was informed that a comprehensive two toilet and a grey-water system could be installed in a house for $7,000 to $10,000. So, if we look at new developments, there really is no reason why this shouldn't be mandated in, given that the costs would already be included in the household.

It may seem costly to install composting toilets in all residences and businesses across Manitoba, but implementing such a system would result in significant long-term cost savings. Consumers would see dramatic reductions in their water bill, as 30 percent to 60 percent of household water use resonates from the toilet. A useful agricultural by-product would also be created. It would be useful for

farmers or people who are growing gardens here in the city. By containing the nutrients at source, less money would be required to maintain our sewage infrastructure, and less money would be required to remove the nutrients at the waste-water treatment facility, if we even need waste-water treatment facilities at all.

Now the need to upgrade our aging sewage infrastructure is really a great opportunity for this province. Fixing our current system is going to be costly, inefficient and onerous. This government does deserve some applause. It took action on regulating phosphorus in cleaning products, and shortly afterward, Québec and the federal government followed suit. Hopefully, this government can be convinced of the benefits of mandating the segregation of urine and feces from wash water. As already noted, more than half of the nutrient loading comes from other jurisdictions. There's not much that we can do about this. However, I think it's pivotal that we clean up our own front yard before we ask our neighbours to do the same.

I just would like to close by acknowledging that the health of our waterways depends on this. Once again, I would like to thank you for your time and consideration, and I would be happy to answer any questions that the committee or even the general public, when time is available, would have.

Madam Chairperson: Thank you for your presentation.

Mr. Cliff Cullen (Turtle Mountain): Thank you very much for your presentation. You certainly put a lot of different issues on the table.

I, too, am a proponent that there is some technology available to us now that can look after some of the issues that we are dealing with, and that dilution is not the solution to pollution.

The other point you did raise, too, I think it's very important that people understand, when we look at manure and waste products, if they are managed in a proper way, they can be a good resource for agricultural producers. That's a very valid point.

You talked about the $1.8-billion project in terms of the waste-water treatment within the city of Winnipeg. The jury is still out in terms of whether we should be removing more than just phosphorus during that treatment. Obviously, the nitrogen removal is a very expensive component to that $1.8 billion. In fact, it may be upward of a billion dollars of that particular cost of that infrastructure.

So you may have answered the question through your presentation, but I guess what I am hearing you say is, at least that $1 billion that's used in nitrogen removal, if that money could be taken and put somewhere else in terms of redirecting it into some of the programs, or the segregation you talked about, or some of the other initiatives, that that might be money more well-spent.

Mr. Beddome: Thank you very much for your question.

Yes, you are right. If you look once again at the chart, I kept focused on phosphorus because of the bill and tried to keep it refined, but urine has 87 percent of the nitrogen, and 10 percent is in the fecal matter. So our grey water has about 3 percent of the nitrogen, a very relatively insignificant source. So 87 percent could be obtained with technology that really isn't much more complex than a big holding tank.

It is necessary that often you store it for six months and you pH adjust it, meaning you lower the pH and then heighten the pH which kills any pathogens that might be existent in there, and, also, you don't spread it directly on vegetative crops, but rather you put it on the ground, or at the time of seeding.

But, as you said, that billion dollars–I don't have numbers; I am not an engineer here, but that billion dollars, if we were using it just segregating our urine, which I don't think would be a costly system, we would get, as I said, a 50 percent reduction in phosphorus, a 54 percent reduction in potassium, an 87 percent reduction in nitrogen, just with that simple act alone. As you said, if we deal with them at source, there are ways of dealing with them, rather than simply diluting them.

Hon. Christine Melnick (Minister of Water Stewardship): Thank you for presenting this evening.

I'm glad that you pointed out the recommendation around emerging technologies and different technologies in the Lake Winnipeg final report. We do have a number of pilots going on, and I would encourage you to think of putting together a proposal and submitting it to the department. We can have a look at that.

Certainly, across western Canada, we see that the technology in waste-water treatment, which removes phosphorus and nitrogen, has been followed by most of the larger municipal and urban areas around western Canada. In fact, I think we might be

following the pack on this one. I know Regina announced, I think, 120 million probably a couple weeks ago for the dual removal. So that is an area that we are moving in, but this government is always interested in innovative ideas. So, again, I would encourage you to think about submitting a proposal to the Department of Water Stewardship, and we'll certainly have a look at it.

Mr. Beddome: Certainly, and thank you very much. I will try to contact your office in regard to putting a proposal together.

I just would like to add that, yes, I mean, sometimes in urban centres it may make some sense to do centralized waste-water facilities, but, as I'm trying to address that, you know, we still need to ask the question. Here in Winnipeg we're going to have to rip up our streets to have a diverted sewer system, as I'm sure you're well aware. That's a substantial cost so that we can segregate them, when we could just segregate them at source. That's where I think we could be innovative. We could be a leader, and we won't be following the pack at Saskatoon, but, rather, Saskatoon will be looking at us, saying, we should be following them. That's what I hope we can do.

Thank you very much.

Madam Chairperson: Thank you for your presentation.

I will now call on Paul Walsh, Dollar Wise Quality Cleaners.

Do you have written copies for distribution?

Mr. Paul Walsh (Private Citizen): I do.

Madam Chairperson: Thank you. Please proceed with your presentation.

Mr. Walsh: Madam Chairperson, Madam Minister, and ladies and gentlemen, I'm here today as a private-corporate citizen, perhaps a hybrid. I'm here to speak only–not on behalf of any group, and, indeed, not even on behalf of the corporation of which I'm president and general counsel, which is the Dollar Wise Quality Cleaners, and that's the last time I'll mention that entity.

I'm here because there's a piece of legislation in front of the Legislature that gives us a great deal of interest, because it's a timid piece of legislation. It focusses on a very unique and special problem that must be solved and must be addressed–and no one quarrels with that–but it's an opportunity for the government and for the members of the Legislature to step back and be much less timid, because we're concerned that the government of Manitoba in this piece of legislation is far too timid.

As an industry leader, you shouldn't be specifying only dishwashing detergent. There are every other kind of detergents, and I would ask you to go back to your Legislative Counsel and consider rewording your legislation so that any detergent that contains phosphates and–don't run the risk of a court or an individual who breaches this legislation doing damage to it. There is laundry detergent. I know a little bit about that, and, by and large, when you go to the supermarket, you can buy laundry detergent that contains phosphates. It shouldn't happen. It shouldn't be. There are solutions that contain no phosphates whatsoever and, more to the point, no carcinogens and no material that anybody would be unhappy having their clothes touched after which their clothes would touch the bodies of themselves and children and infants, et cetera. Don't be timid with this legislation. Toughen it up. Toughen it up so that it touches on every product that contains phosphates, and use this as an opportunity to consider legislation that is broader.

***** (20:00)

What you have done is you've apprehended a problem and you're solving the problem with a shotgun approach, whereas a much broader approach is warranted. Focus on other cleaning products. As you can see from the literature which I've distributed, it's quite possible, and indeed probably likely, that without legislation, over a long period of time, industries will go green. It's a good thing to do. The only thing we don't want to go green is our lakes. We want them to stay reflecting the sky and stay blue. Going green is a good idea, and there ought to be more than a wink and nudge but a shove and a push from government to do that.

And you know, and everyone knows, that California as a jurisdiction has given its dry-cleaning industry 15 years to stop using a solvent called PERC. In the material that I've distributed, there's a lot of information about this toxic product, PERC. I won't give you the whole name because if I pronounce it, I'll have done it once and for the only time and you'll never be able to pronounce it again, but it's known in that way and it's caused irritation and the people who work in dry-cleaning plants, at the end of their work life, have a higher incidence of

cancer than those who work in other industries. You can connect those two dots quite easily.

What I'm here to say to you today as a private corporate citizen is that this is a baby step. This is a baby step that deals in a very narrow way with a very particular problem that all Manitobans should be grateful. You've perceived the problem. Everybody knows about it. I mean, as you get into a circle to pat each other on the back ahead of you, it's the kind of legislation that nobody quarrels with. Why I'm here today is to ask you to use this as the first step in bringing forward major environmental legislation.

Darren Praznik, who spoke earlier, warned you about how bad it would be if small jurisdictions did things when they could co-operate in the big picture. Well, okay, but if products are carcinogens or may cause cancer, if products are toxic, if products are ruining our water systems, then we can't wait for other jurisdictions. We can be a leader here.

My industry needs leadership, and we think we've given it. Leadership can come from government that says, over time, here are target dates, we're going to ban certain products, and I would ask you to look very carefully at the dry-cleaning industry, which is using toxic products, phosphates being one of them, and to see that we've taken a leadership role. We don't use any product containing phosphates in our operation and no cleaner need do that, either commercial or at home, and no dry cleaner need use products that are injurious to the health of workers in any of its plants.

The reason I'm here as a private citizen, when I found that this bill was being considered, is not to speak in favour of the bill, certainly not to oppose it, because no one is against it, but to ask you to use this opportunity to have an environmental minister–not a minister responsible for the environment–to bring forward much more legislation because much more is needed. Industry, private citizens won't do it on their own, and that's why I'm here.

So thank you very much.

Madam Chairperson: Thank you for your presentation.

Ms. Melnick: Thanks very much for your presentation as well.

You'll notice, as you peruse the bill, that there certainly is a lot of opportunity for a lot more inclusion. This is the start and certainly, when we're ready to move forward in the areas that you're suggesting, I'll make sure to get back in touch with you.

I think it's also important to recognize that Manitobans–certainly Manitobans that I've spoken to as Minister of Water Stewardship–are very happy with this bill and are very much in favour of what it is that we are doing as their government and, in fact, the question that I get asked more often is, How do I make sure that those products are in my local store? I know the work that you've done will also help in the area that you work in to help with cleaning up Lake Winnipeg, but also the other health threats of a human nature.

Thank you very much for coming out this evening.

Mr. Walsh: Thank you for having me, and all I'm here to say is to toughen up and broaden it out, so thank you.

Madam Chairperson: Thank you very much.

Bill 18–The Testing of Bodily Fluids and Disclosure Act

Madam Chairperson: I will now call on Jodi Possia, Paramedic Association of Manitoba, on Bill 18.

Do you have written copies for distribution?

Ms. Jodi Possia (Paramedic Association of Manitoba): Yes, Madam Chair, my written documentation was delivered this afternoon and should have been circulated.

Madam Chairperson: Okay. Thank you.

Please proceed.

Ms. Possia: Thank you, Madam Chair, and ministers and legislative members. Thank you for the opportunity for the Paramedic Association to speak on Bill 18.

By means of introduction, the Paramedic Association of Manitoba is a voluntary-membership professional association for emergency medical services personnel licensed to practise in this province. Representative of both rural and urban practitioners, we strive to promote excellence in pre-hospital emergency health care and within our profession.

The Paramedic Association of Manitoba is a chapter of the Paramedic Association of Canada, the professional organization representing over 14,000 para-medicine practitioners across Canada.

Our association is not a union or a labour organization. The mission statement for the Paramedic Association of Manitoba defines our organization as a professional association comprised of licensed pre-hospital practitioners across Manitoba with a strong voice in EMS issues that promotes the well-being, safety, and appropriate medical treatment for our patients.

It is my pleasure as vice-chair of the Paramedic Association of Manitoba to address the social and economic development committee on the subject of Bill 18.

We were present in the legislative gallery just two weeks ago, when the honourable Minister of Health (Ms. Oswald) introduced this very important piece of legislation. Today, as we meet to discuss Bill 18, we congratulate the government for recognizing the need to take measures to protect the many paramedics, police officers, firefighters, and Good Samaritans who give selflessly of themselves each and every day to help others in their time of need and, as well, we thank all of the members of the Legislative Assembly for supporting this initiative.

The Paramedic Association of Manitoba has long been a proponent of legislation that would permit mandatory blood testing if emergency providers were faced with a possible high-risk, significant personal exposure to body fluids.

Provinces in Alberta, Saskatchewan, Ontario and Nova Scotia have all adopted blood-testing legislation to ensure their first responders, paramedics, police and corrections officers, firefighters and good Samaritans have access to the information necessary to make educated, appropriate and timely decisions regarding treatment and follow-up in these unfortunate instances.

A significant exposure occurs when body fluids capable of transmitting hepatitis B, hepatitis C and HIV come into contact with open or broken skin, mucus membranes in the eyes, nose or mouth, or underlying tissue as a result of a puncture or a cut.

The bodily fluids considered capable of transmitting these infectious diseases include blood, saliva, secreted fluids contaminated by blood and other cavity fluids, including amniotic fluid in childbirth, and cerebral spinal fluid.

Despite the best efforts of paramedics to take appropriate precautions, to limit the possibilities of significant exposures and even with other legislated safety measures already in place, the very environment in which we work results in a potential for these exposures to occur that cannot be completely eliminated.

***** (20:10)

It is the unfortunate event that emergency services personnel or helpful bystanders suffer a significant exposure while providing care to others. It is imperative that they are able to obtain in a timely manner information about the source individual that allows them to make more informed personal and professional decisions. The concept of mandatory blood testing is often challenged by the argument that it is a violation of privacy and contravenes the Charter of Rights and Freedoms. On the contrary, in the context of illness that may result from a significant exposure to bodily fluids, it should be argued that the denial of blood sampling is a clear imbalance of rights in favour of the source individual.

In these cases information relating to blood-testing results and risk factors can assist exposed persons in decision making related to both their private and professional lives. When you consider the dangers faced by emergency workers on a day-to-day basis, mandatory blood testing is not a lot to ask. Statistics within the city of Winnipeg show there were approximately 20 significant blood exposures reported by paramedics in 2005. Data obtained from just three of the 10 regional health authorities outside of the Winnipeg indicated there were 10 significant exposures in these areas in 2006.

In November of 2006, another regional health authority experienced an incident in which two paramedics assisting hospital staff aiding to an elderly, very agitated and confused patient were exposed to bloody urine when medical tubing became dislodged. One paramedic received a significant exposure to their eyes; the other to broken skin on his face.

In December 2006, a Winnipeg police officer was struck by a bullet that passed through the hand of a suspect during an arrest attempt. Just weeks ago, both paramedics and firefighters reported significant body-fluid exposure while attending to a shooting in downtown Winnipeg.

Bill 18 provides a measure of comfort and security for those front-line paramedics and emergency services personnel, as well as for their families and their loved ones. While the risk of infection as a result of an exposure to bodily fluids is

estimated to be very small, it is not insignificant. There is no cure for hepatitis B, no cure for HIV, or AIDS and these diseases can be fatal. Documentation prepared for the Canadian HIV/AIDS Legal Network concludes information about the serological status, risk factors and medical history of the source person can relieve uncertainty as to whether there was, in fact, an exposure to hepatitis B, C or HIV and can contribute for decisions about preventing further transmission, decisions around post-exposure prophylaxis and the follow-up for exposed workers.

The Canadian Medical Association has determined that a patient's refusal to be tested following a high-risk exposure will impair fully-informed decision making concerning post-exposure protocol, increase health-care workers' anxiety and possibly result in unnecessary post-exposure protocol side effects.

Studies have shown that the consequences of occupational exposure to blood-borne pathogens, whether infectious or not, cause psychological trauma to countless numbers of health-care workers each year during the months of waiting for notification or for their serological results. Blood-testing legislation, while not a cure for this stress, will address the issue and allow emergency personnel and Good Samaritans to make more informed decisions regarding personal and professional practices following such exposures. Concern regarding mandatory blood testing must also be weighed against the relative infrequency of the source individual refusing to be tested. Surveys conducted in both Canada and the U.S. conclude that 83 percent and 94 percent of individuals do, in fact, agree to be tested when the importance of the information is explained to them.

Bill 18 provides a measure of security in those few instances when agreement cannot be obtained. As we understand the intent of the bill, the ability to apply for an expedited testing order when appropriate will make this the most responsive legislation of its kind in the country. Clause 23 subsection 1 providing for this legislation to have prevalence over other acts shows a strong commitment to balancing the rights of the applicant with those of the source individual. We will look forward to the possibility of further consultation regarding the development of regulations pursuant to this legislation. It will be our recommendation that stakeholders be encouraged to work collaboratively to educate those affected by this legislation, not only in areas related to access and process but also to enhance personal protection. As an example, we'll suggest looking to the use of electronic media, as has been done in Ontario, clearly outlining potential risks, steps to follow in the events of suspected significant exposure, and other frequently asked questions.

Paramedics, first responders, police and corrections officers, firefighters, Good Samaritans must cope with the consequences of possible exposure to infectious disease each and every day–consequences including anxiety, the increased stress associated with uncertainty, side effects resulting from prolonged post-exposure prophylaxis, the impact that exposure has on certain measures within their private and professional lives. These are all very significant. This legislation sends a very good message to those individuals and provides an additional avenue of hope in a very difficult circumstance.

Thank you very much.

Madam Chairperson: Thank you for your presentation.

Do the members of the committee have any questions?

Mr. Kelvin Goertzen (Steinbach): Jodi, thank you for your presentation, very thoughtful and articulate. I also want to thank you for the long-standing advocacy your association has had on this legislation.

Not to correct my colleague from Turtle Mountain, but I do want to put on the record, a couple of years ago when we brought forward private member's legislation to bring this concept forward to the Legislature, while I had the opportunity to sponsor that legislation, the idea actually came from a gentleman by the name of Ray Rempel, who is a paramedic with the Winnipeg paramedic association.

I would have liked to have seen him here tonight, but he is expecting his second child. I think his wife was a week overdue, so he might have more pressing needs than a legislative committee tonight. But I do want to recognize Mr. Rempel as the person who brought this forward to me and was a strong advocate. I hope that your association takes a special recognition of his advocacy work, and I hope you have a special connection to the legislation because you're a big part of it. So thank you very much.

Hon. Theresa Oswald (Minister of Health): Madam Chair, I'd like to go on the record of

acknowledging Mr. Rempel's good decision making this evening, not ever having met his expectant wife, but call it a hunch.

Second of all, I do, of course, want to extend my gratitude on behalf of all members of the Legislature, if I may be so bold, for the efforts that the paramedics association has made in seeing this legislation come to the floor. I know that your members have had a very important voice in this dialogue and a dialogue that as you have acknowledged quite rightly in your submission is not a smooth one, not an easy one.

Certainly, the Member for Steinbach (Mr. Goertzen) has brought this issue forward as he's just acknowledged. I know that it's an issue that the former Minister of Health and current Attorney General (Mr. Chomiak) has worked its way through for some time now. The Member for Transcona (Mr. Reid) as well has taken a very active interest in this and knowing that we needed to come forward with something that would address these issues of timely information gathering, as you so rightly pointed out, while at the same time balancing those very important voices that come from, dare I say, the other side of this issue. That is the maintaining of one's basic human rights, something that we always have to take into consideration in all that we do in the Legislature.

I think that you've made a very important point in your submission about the fact that no legislation in the world is going to protect, and I believe I've been guilty of that myself, in using that language about protecting paramedics and firefighters. When a significant exposure occurs, it has occurred, and no piece of paper in the Manitoba Legislature or elsewhere can change that. It's what we do with the information that we gather afterwards that will be so critical, and your words about education and us working together with members of your profession, the public. There are so many Good Samaritans in Manitoba; they need to know about this, about what they can do to gather information and to be taking the post-exposure prophylaxis as appropriate as a result of the significant exposure.

So thank you for your words. I'm going to thank you in advance for the work we're going to do in the days ahead so that people really know about what this legislation is, what it is not, and what we can do to keep ourselves safe as you go out there every day to protect us and help us. So, thank you.

***** (20:20)

Ms. Possia: Thank you very much, Minister Oswald, and we do hope that bringing this bill forward does encourage the development of education around protecting yourself as a practitioner in the field.

If I could address Mr. Goertzen, thank you for your advocacy on blood samples legislation, and I do know Mr. Ray Rempel very well, and I encouraged him to be here today. So, yes, thank you very much.

Madam Chairperson: Thank you.

I will now call on Alex Forrest, United Fire Fighters of Winnipeg. Do you have written copies for distribution?

Mr. Alex Forrest (United Fire Fighters of Winnipeg): Yes, I do.

Madam Chairperson: Please proceed.

Mr. Forrest: Thank you, Madam Chair, Honourable Minister, MLAs.

I would like to begin by thanking the committee for giving me the opportunity of discussing this important piece of legislation this evening.

IAFF firefighters in Manitoba and across Canada have been lobbying for this legislation both federally and provincially since 2001, not only in Canada but also in the United States.

The International Association of Fire Fighters represent Manitoba professional firefighters in Winnipeg, Brandon, Thompson, Portage la Prairie and Pinawa, approximately 1,600 members.

Winnipeg firefighters provide emergency care from the first responder level to that of licensed paramedic.

Brandon and Thompson firefighters provide exclusive emergency medical services from transport to advanced paramedic levels. Portage la Prairie and Pinawa provide first responder medical care.

The IAFF is the largest labour organization in the world that represents professional firefighters and paramedics, approximately 300,000 members.

Now that we have had a chance to look at the legislation and also had our experts in Washington and Ottawa examine it, we can make the following statements.

Legislation of this type is always flawed in some way due to the time constraints of preventative treatments when there is a blood exposure. Preventative treatments must be started within hours

of a blood exposure and this legislation will not change that.

This legislation will minimize the time needed to be on the preventative drugs and above all, it will alleviate the anxiety of not knowing what is in that blood much sooner than it is the case today. But most importantly, because of the court-assisted aspects of this legislation, it will not only be one of the strongest pieces of legislation of this type in Canada, but throughout North America.

Also, due to the strength of the legislation it will serve as a tremendous tool to educate the citizens and first responders of Manitoba.

I congratulate the Minister of Health, Theresa Oswald, and the government of Manitoba for putting forward this legislation that is so very important to the first responders of this province.

I would now like to read into record a statement by a fire captain. One of his crew recently had to deal with a severe blood exposure. His statement is the best way that I can think of to describe why we need this legislation.

"My name is Jim Hemphill. I am an Acting Captain and have 27 years experience with the Winnipeg Fire Department. I was the captain at the scene of the recent triple murders on Alexander Avenue. One of my firefighters sustained a significant exposure of blood in the mouth and eyes as he was doing CPR on one of the victims. The victim was pronounced dead at the hospital. The firefighter went to emergency and had his blood taken. He was then told to take strong anti-viral preventative medication for the next three days while his blood was being tested. The firefighter's test came back negative, but because the victim's blood could not be tested, the firefighter was on medication for the next four weeks. All this as a preventative measure because they could not get a blood sample from the victim.

"In fact, the firefighter had a negative reaction to the potent drugs. The reaction was serious enough that he has been taken off duty and has been on WCB for the last two weeks. He will also have to have his blood checked every three months for the next half-year to see if anything arises. He carries with him the burden that he may have contracted something and is unknowingly carrying it and possibly passing it on to his loved ones.

"Imagine being scared to hug your kids or kiss your wife!

"We know that in situations such as this, we will always need to begin preventative treatments, but this legislation will greatly reduce the amount of time needed to be on these drugs. It will relieve the anxiety related to not knowing what was in that blood.

"Sadly, this is part of our job and is what we get paid to do, but, in performing our duty, we should have all the protection available to allow us to live our lives, both on and off the job, with the security of knowing that everything that can be done, is being done to protect us and our families.

"Thank you for allowing me to make this statement, and I commend you on this important initiative."

Thanks.

Madam Chairperson: Thank you for your presentation.

Do members of the committee have questions?

Mr. Goertzen: Just quickly, Mr. Forrest, thank you very much for your presentation.

You're witnessing one of, I don't want to say the rare moments of unanimity in the Legislature, but certainly one of the more overwhelming moments of unanimity here. So, just on behalf of our party and I think all members of the Legislature, thank you for the work that you and your members do. We also look forward to speedy passage of the legislation. So, thank you very much.

Mr. Forrest: Yes, above all, we want to thank everybody in the Legislature. I think it's very important at times like this we come together, we understand what's important, and you should all be proud of this legislation. It's a very good piece of legislation.

Ms. Oswald: Thank you, Mr. Forrest, for the presentation. You certainly have articulated, through your statements and the statement of the individual you spoke of, how complex these issues can be and emotional indeed.

I just want to commend you today, and every day really, for the work that you do going into buildings that we're going out of, but also the work that you've done so passionately ensuring that legislation in our province has been in the lead in so many respects when it comes to protecting our front-line workers. It's really an important kind of advocacy that you do, and we thank you for that.

Mr. Forrest: Yes, again, I would like to not only thank the NDP, but every party. We have been so fortunate as being firefighters, first responders, to getting the support that we have from the Legislature, and it's not only on this issue but many issues. Again, from the bottom of our hearts, thank you very much.

Madam Chairperson: Thank you for your presentation.

I will now call on Mike Sutherland, President of the Winnipeg Police Association. I understand yours is a verbal presentation. So, please proceed.

Mr. Mike Sutherland (Winnipeg Police Association): That is correct, Madam Chair.

First, I'd like to thank the committee for inviting me to make a brief presentation today on this very, very important issue. I will apologize initially for my shortcomings, as I'm a very newly-minted president of the Winnipeg Police Association, as this is my first day and this is the first opportunity that I've had to make such an address. So, if I make any mistakes, I beg for your forgiveness in advance.

In lieu of reiterating many of the comments made by my brother and sister organizations in the emergency response field, I'd like to perhaps add a unique perspective with respect to my submission. But first, I'll just qualify who I represent. I represent roughly 1,670 members of the Winnipeg Police Association, approximately 1,300 of those are sworn peace officers, as well as a staff component. Almost on a daily basis, we face a number of risks, and I'll talk to you specifically from a personal perspective, one that I feel is particularly relevant given the nature of the legislation that we're discussing now.

***** (20:30)

I personally faced a significant exposure a number of years ago during the course of my duties as a police officer in uniform in Winnipeg. By way of circumstance, I can tell you that there was a situation where we had a suicidal male, who had jumped from a moving vehicle directly in front of our cruiser car, and tried to throw himself into the path of oncoming traffic. As a result of jumping from the moving vehicle, he sustained a significant head wound and, as a result, in order to bring him under control, I had to physically intervene in a very rapid fashion and suffered significant blood exposure both to my eyes, nose, mouth, as well over my entire uniform.

I can tell you that the course of the prophylaxis can only be described as severely uncomfortable. The headaches and fatigue that I experienced over the course of my treatment were extremely debilitating with respect to the conducting of my subsequent duties. The doubt and the inability to know about the exposure or risk I faced was very significant and very stressful.

When we talked a little earlier, we all realize that this legislation doesn't protect emergency service personnel from exposure; however, I think it does offer a small element of protection to the families of those individuals because, with knowledge and certain knowledge, comes the ability to act accordingly. It's very difficult for police officers not to be able to lean upon those who provide emotional support and that's our families. Close contact with our spouses and close contact with our children is definitely one way in which we cope on a daily basis with the many stressors associated with our duties.

So, on behalf of the men and women of the Winnipeg Police Association, I would first like to sincerely thank you, from both a professional and personal level with respect to having the courage to bring this legislation forward. I cannot understate the importance to the people that we represent, the overriding desire to have this legislation brought forward in a very rapid fashion. On behalf of the men and women of the WPA, I want to sincerely thank you for bringing it forward. Thank you.

Madam Chairperson: Thank you for your presentation.

Do members of the committee have questions?

Mr. Goertzen: Comment to Mr. Sutherland, first of all, congratulations on assuming your new role as president of the Winnipeg Police Association. I had the opportunity to work with your predecessor for a number of years, Mr. Schinkel. You know that you have big shoes to fill, but I'll certainly pass on to him–I know he advocated for this legislation for a number of years, and I'll be able to tell him proudly you got it through the committee on the first day of the job. I know he'll take that in the spirit that it was given.

But I do want to thank you for your presentation to the committee. You brought forward a very meaningful personal experience which I think helped each of us understand more personally the difficulties that you go through as a police officer because it is a challenge for us who don't do the job

to always understand the dangers that you face on a day-to-day basis and that we sometimes take, I think, your work for granted. We never should because you're out there each and every day in difficult situations that most of us will never have to face or can't possibly understand given the nature of the work that we do.

So, on behalf of our party and all members of the Legislature, we just want to thank you for the daily service that you give, and we want to wish you well in your new position as the president of the Police Association. Thank you.

Mr. Sutherland: Well, I'd like to thank you very much for your kind words.

First of all, yes, I do recognize the shoes are rather large, and I'll take this opportunity to relish this small achievement or this major achievement, actually. I do appreciate, first of all, the actions of both the government and members of the opposition in coming together for this very, very important legislation on behalf of those that serve to protect the citizens of Winnipeg in all capacities, whether it be the fire service, the paramedics, or the police.

Ms. Oswald: I think you can chalk this up to a very good first day from my perspective. I want to thank you also for your very personal and passionate story that really is so much more than that. There are a lot of voices that have come to bear on this debate.

You know, another coming up this evening, the submission that was referenced earlier from the Canadian HIV/AIDS Legal Network, which is a fine body of work and, again, such an important perspective as we go forward and try to balance the most precious of human rights. I don't mind saying it's not necessarily a slam dunk as we have these discussions, but I think that the story that you have told goes a long way to help us all understand how important it is that we really do the work and try to find that balance that some people may not believe actually exists. I believe it does. I believe it's entrenched in this legislation, and I think that your voice is an important one to bear in that pursuit of a balance.

So I thank you very, very kindly for your time here this evening.

Mr. Sutherland: Thank you, Madam Minister.

I'd just like to add with respect to your comments that police officers, their basic function is to protect the rights of the individual. We don't enter into a situation lightly where there is a potential perspective where people might feel that their rights are being infringed upon. However, in many cases, and I know in my own personal case, it didn't boil down to choice for me; it boiled down to duty and to act quickly. Unfortunately, there is a balance that needs to be struck, because we all have rights.

Our families and we as police officers, we as fire fighters, we as paramedics, have rights and require some level, I believe, of protection ourselves when we seek to protect the rights of others. This is not a request made lightly and not without due consideration, but we feel that the legislation addresses those situations. We hope that it will move forward quickly.

We thank you very much.

Madam Chairperson: Thank you.

I will now call on Ken Mandzuik, Manitoba Association for Rights and Liberties. Do you have written copies?

Mr. Ken Mandzuik (Manitoba Association for Rights and Liberties): I do.

Madam Chairperson: Please proceed.

Mr. Mandzuik: Thank you, Madam Chair, Madam Minister, honourable members. I feel more outnumbered tonight than I usually do when I come down here.

I'm Ken Mandzuik. I am the past president of the Manitoba Association for Rights and Liberties. MARL is a provincial non-profit, non-government volunteer organization that's been around since 1978. We're here to advocate for human rights and civil liberties. Our objectives are to promote respect for, observance of, fundamental human rights and liberties, and to defend, extend, and foster the recognition of these rights and liberties in the province.

We appreciate the opportunity to address the committee on Bill 18. I'll start by saying that I have had the chance, or we have had the chance to review the submission that the Canadian HIV/AIDS Legal Network circulated a couple weeks ago, I think, to all parties of the House. We do support the position that they have outlined. We also recognize the intention behind the proposed legislation and that it comes before this committee on the Day of Mourning, recognizing workers that are hurt or killed, injured, or fall ill on the job, is a coincidental reminder of the good intentions of the House and certainly of the

jobs that are done by the people this bill looks to look after.

Our general concerns are essentially that of privacy rights, as you may have guessed. The Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and, of course, the Charter of Rights and Freedoms all protect all of our rights to privacy. Former Justice La Forest of the Supreme Court of Canada has said that privacy is at the heart of liberty in a modern state. Without that right to privacy, all of our other liberties would mean nothing, the right of freedom of association, the right of freedom of speech, would mean nothing if we couldn't exercise those rights in private.

***** (20:40)

Privacy regarding one's medical information, their bodily integrity, are vitally important components to the right of privacy and deserving of vigilant protection. The Supreme Court has talked about privacy protection as found in section 7 of the Charter, which guarantees the rights and security of the person. In the Morgentaler case, the court said section 7 guarantees to every individual a degree of personal autonomy over important decisions affecting their lives. In the Sue Rodriguez case, the court said section 7 protects the dignity and privacy of individuals with respect to the decisions concerning their own bodies and, obviously, more clearly, section 8, which protects us all against unreasonable search and seizure. All of these things protect the rights of privacy and, on the face of the bill, those rights are infringed, and we don't submit for a second that these rights are absolute. There is, in section 1, a balancing test that you're aware of that subjects these rights and the other rights in the Charter to reasonable limits.

The court would go through a four-step analysis and what's called the Oakes test that you might be familiar with. The first thing that would have to be satisfied is that there is a pressing and substantial need that the legislation is addressing, and, based on the information that we have seen, there has been one case of occupational HIV contamination in Canada. The pressing and substantial need simply isn't present.

The second arm of the Oakes test is the rational connection. The court has to be satisfied whether there is a connection between the legislation and the objective of the act. That is, simply, is it effective. Nothing in the legislation as it's drafted shows this. Testing someone cannot change the fact that there has been exposure. Testing a source individual cannot prevent exposure and can only rarely confirm the need for treatments, treatments that to be effective are likely going to be started before any test results are back.

There's been some comment about alleviating stress and concern, and, obviously, my remarks don't take away the very real stress and concern that someone facing exposure is going to feel, but the testing legislation could actually increase that stress. If the figures in the Canadian HIV-AIDS materials that I've reviewed are accurate, if someone is infected with HIV and there's been a significant exposure, there's a 0.3 percent chance of being infected. So, even though someone might come back with a positive test, you're going to feel stress and worry, even though the chances of your being infected are still remote.

The stress and anxiety that one might feel is not going to be eliminated if there is a negative result because you could still be in that window of exposure, where you've heard other presenters talk about having to get tests up to six months after their exposure. That does not change with this legislation.

The third requirement under the Oakes test is that the infringements on an individual's rights are as minimal as possible. In the expedited testing procedures, there doesn't need, on my reading of the bill, to be any evidence that the source individual was even asked to provide a sample. There's no requirement that the source individual has to refuse to provide a sample. The infringements that we're talking about are so considerable, bodily integrity, confidentiality, dignity. All of these things are lost or infringed by the legislation.

With the invasion of privacy of such a magnitude, the invasiveness has to be something less, and how could it have been–it could have been more intrusive. There could have been an order compelling physically someone to undergo a test, but there are other alternatives available that are going to more happily address some of the concerns without such an invasion.

Education is one thing. Hugging and kissing kids is not going to give anyone HIV. Public education obviously needs work. There's education that could be done about minimizing risks to exposure, things to be done after exposure, alternative equipment, whether it by the Kevlar gloves we heard about, alternatives to needles, money going into safer-sex

education, needle exchange programs, that sort of thing. The test for minimal impairment of rights is not met.

The final test under the section 1 analysis is proportionality. This is the ultimate weighing. How bad is the infringement of rights compared to the good that the bill is trying to address, and the benefits that the bill may provide are more apparent than real and are significantly outweighed by the infringement to an individual's personal liberties.

We know that this bill has all-party support and support of, obviously, a whole bunch of people, but if it's such a great idea, why does the bill not go both ways? Why, if I am being treated by a paramedic, and I have been exposed, what if the source individual is a paramedic? Why do I not have the right to go and have similar tests forced? We wouldn't support legislation to that end, obviously, but one wonders why it would not go both ways, so to speak.

A couple of specific concerns just on more technical points.

In section 3, I've already commented on the lack of requirement for a source individual to refuse or deny blood testing. In overwhelming circumstances or overwhelming number of cases, that is going to happen. Someone is just going to consent and none of this is an issue. That should be a prerequisite. That is clearly set out in the act, not in regulations.

The expedited testing order, as a concept, is problematic. In section 6(1), talking about what has to go before a JP, over the phone is very, very limited, given the affront to the personal liberty that we're talking about. One would expect, at minimum, medical evidence suggesting that such a test, such an invasive procedure is warranted, especially when no notice is offered to the person, the source individual. We do note that in the more expanded standard testing order, one has to provide that kind of evidence to a Justice of the Court of Queen's Bench. Ideally, if there's going to be an expedited procedure, those minimum requirements should be duplicated.

In section 7, the 24-hour notice period to register an objection. I'm happy to see in the legislation, registering an objection; it does seem easy to do, easy enough as picking up a telephone, but one wonders in the circumstances where there might be an exposure, how able is someone going to be to have the wherewithal to consult with medical professionals or a lawyer or whoever he or she needs to, to make that telephone call within 24 hours.

Finally, section 19. There are confidentiality provisions in the bill. We're not necessarily keen that the bill trumps PHIA or the other privacy legislation in force, but the confidentiality provisions, as they are, could be strengthened. The very fact an application has been made ought to be confidential. There ought to be the provision in the act explicitly to allow for in-camera hearings or for publication bans.

In closing, I would like to thank you for your attention and urge that you reconsider not passing this legislation. Thank you.

Madam Chairperson: Thank you for your presentation.

Do members of the committee have questions?

Mr. Goertzen: Thank you very much, Mr. Mandzuik. Thank you for your presentation. I know it wasn't easy to come and present because there certainly were many other compelling arguments before you, but I think you bring an important voice to the discussion.

I want to assure you that, when I was looking at and bringing forward my own private member's legislation, it wasn't without thought to the issues that you raise. I did some of my own analysis on the Oakes test in this section 1 saving provision of the Canadian Charter of Rights and Freedoms. Certainly nobody wants to pass legislation that, while all legislation can be tested, we still want it to pass the scrutiny of the courts. I'm not entirely sure that it would require a section 1 saving provision. There certainly are many competing interests in the Charter. We have the right to freedom of speech but it's not unfettered. We can't have hate speech because of other regulations. We have the right to freedom of religion, but that often comes into conflict with equality rights protected under the Charter. One can look at the different definitions of security of person.

The question specifically that I have for you is in the cases that deal with the ability or the consent that a person has to give for medical treatments. Most of the cases that I read didn't have a counterbalance to it, in that it was just one individual saying, I'm not going to give my consent to medical treatment. But there wasn't a competing interest. In this case, the competing interest would obviously be the paramedics, firefighters, police officers on the other side.

Do you think that that's compelling enough? Certainly, the drinking and driving legislation where we're allowed to take blood to test blood there was a given, as a competing interest, a societal interest. Do you think that this is enough of a competing interest to ensure the legislation withstands any challenge that it might receive in the courts?

***** (20:50)

Mr. Mandzuik: No, I don't. I'll just point out, when you're looking at blood testing on something like drinking and driving, there's got to be some threshold met that there's a wrong committed. There's no threshold like that in this legislation.

Mr. Goertzen: I don't want to get into a debate of law about reasonable cause on drinking and driving and that sort of thing. I just do want to appreciate your comments. I don't want you to think that they have gone unheard, even though I am, obviously, an advocate in support of the legislation. I do want you to know that I did think through many of the considerations you brought forward.

Mr. Mandzuik: Thank you.

Ms. Oswald: I wanted to go on the record that I might have enjoyed that debate, but the evening is wearing on.

An Honourable Member: You can still have it.

Ms. Oswald: Yes, indeed.

I want to thank you very much for your voice in this conversation. While you may have felt somewhat alone in the room this evening, certainly, you know very well, as I do, that you are not, and that there have been a number of people who have raised concerns about the basic principles in this.

It really is at the very essence of why we needed to take our time, and have taken some criticism for that. When we're endeavouring to balance the very important issues that you have raised with the equally as important issues, as many of the people in our audience tonight have raised, we wanted to work hard to do the best that we could to get it as right as we could.

On the issue of insisting that there's voluntary, an asked-for voluntary compliance entrenched in legislation, we looked at that very carefully and found it to be simply contra-indicated in the case of victims of crime. The notion of a little old lady being required, in law, to ask her batterer for a blood sample voluntarily was, indeed, problematic.

While we know in neighbouring jurisdictions, Saskatchewan, I believe, has a 99 percent success rate in seeking voluntary samples, and we, too, hope to beat Saskatchewan in that regard, we felt putting it into legislation itself, in those rare cases for victims of crime, would be a problem.

Secondly, I would say that our efforts to have the expedited order makes this legislation legislation you don't like, but the best of legislation you don't like in Canada, in that it, on the one hand, will afford our front-line workers an opportunity to have that as quick as possible response, but, at the same time, it does entrench the ability for a source person to say no, which we find does not exist in legislation elsewhere on the continent, quite frankly. We believe that the balancing of that very fundamental human right is what is going to allow us to have the best legislation of this kind.

We would hope that in all cases, with education, as you and others have so rightly pointed out, which needs to be a big package, as this bill goes forward, that we'll be able to assist people in understanding how important that sample being provided can be to the peace of mind of these individuals, that it will happen 100 percent of the time voluntarily, but, in those very rare cases where it does not, we believe that, on balance, having this kind of legislation for information to come forward will go a long way to assist those who work so hard to assist us every day.

I respect fully your points of view on this issue, and I'm glad that you're here tonight.

Madam Chairperson: Time for questions has expired. Thank you very much.

Mr. Mandzuik: Thank you.

Madam Chairperson: That concludes the list of presenters I have before me.

Are there any other persons in attendance who wish to make a presentation? Seeing none, that concludes public presentations.

In what order does the committee wish to proceed with clause-by-clause consideration of these bills?

Mr. David Faurschou (Portage la Prairie): Bill 18, and then numerical.

Madam Chairperson: Is it the will of the committee to do Bill 18 first, and then the remainder numerically? *[Agreed]*

Bill 18–The Testing of Bodily Fluids and Disclosure Act

Madam Chairperson: Does the minister responsible for Bill 18 have an opening statement?

Hon. Theresa Oswald (Minister of Health): I think I've just had six opening statements in a row, so thank you, Madam Chair, we can proceed.

Madam Chairperson: Does the critic from the official opposition have an opening statement?

Mr. Kelvin Goertzen (Steinbach): I only want to clearly say and there's been some discussion about who's bill was it and when did things come forward first and those sort of things. I think the minister and I would agree that this is not our bill. It's the bill that belongs to the paramedics, the firefighters, the police officers, the victims of crime and others who might use it. So, just clearly for the record that's whose bill this is. That's who it's for, and we look forward to its quick passage and proclamation.

Madam Chairperson: We thank the member.

During the consideration of a bill the table of contents, the preamble, the enacting clause and the title are postponed until all other clauses have been considered in their proper order. Also, if there is agreement from the committee for the longer bills I will call clauses in blocks that conform to pages, with the understanding we will stop at any particular clause or clauses where members may have comments, questions or amendments to propose. Is that agreed? *[Agreed]*

Clause 1–pass.

Shall clauses 2 and 3 pass?

Mr. Goertzen: Just a question on clarification, Madam Chairperson. Under section 2(1) where it outlines who has access to the bill and, of course, we've heard from many of those who would. I just want to ensure that the definition of peace officer, and I'm sorry I don't have my police act with me tonight, I left it at home. But is there an assurance that a peace officer would include correction officers in Manitoba prisons?

Ms. Oswald: Yes.

Mr. David Faurschou (Portage la Prairie): Just along that line of questioning would that also be inclusive of those that serve the Legislature and other government facilities in security positions?

Ms. Oswald: I'd want to make absolutely sure so I'll need to consult on that issue, and I'll get back to you.

Mr. Faurschou: Is the minister expecting a response as we wait now?

Ms. Oswald: It's not explicit in the way the wording is laid out. Certainly, in the case of these individuals being the victim of a crime they would be captured in that regard. There is a provision under (d) for, and others, for us to make specific reference to those kinds of individuals and others that we may come up with as we go forward in the discussion of regulations.

So they will not be explicitly excluded forever more. There's an opportunity for us to capture that later as needed.

***** (21:00)

Madam Chairperson: Clauses 2 and 3–pass; clauses 4 and 5–pass; clause 6–pass; clause 7–pass; clauses 8 through 11–pass; clause 12–pass; clause 13–pass; clause 14–pass; clauses 15 and 16–pass; clauses 17 through 19–pass; clause 20–pass; clauses 21 through 25–pass; clauses 26 and 27–pass; table of contents–pass; enacting clause–pass; title–pass; Bill be reported.

Bill 8–The Phosphorus Reduction Act (Water Protection Act Amended)

Madam Chairperson: We will now do Bill 8, The Phosphorus Reduction Act (Water Protection Act Amended).

Does the minister responsible for Bill 8 have an opening statement?

Hon. Christine Melnick (Minister of Water Stewardship): Yes, thank you, Madam Chair.

To speak to this bill, I think it's very important to recognize that the bill amends The Water Protection Act. It deals with the reduction of phosphorus released into Manitoba's waters from cleaning products such as dishwashing detergents. We can expand to include personal care products and chemical water conditioners.

I was very proud as the minister to be the first to bring forward such legislation in Canada, very pleased that Québec followed, and I'm looking forward to having national legislation brought through by regulation by the federal government. So I think it's very important that we recognize that this is the start.

Thank you.

Madam Chairperson: We thank the minister.

Does the critic from the official opposition have an opening statement? There is no opening statement, thank you.

Clauses 1 and 2–pass; clause 3–pass; clauses 4 and 5–pass.

Shall the preamble pass?

Mr. Kevin Lamoureux (Inkster): I just wanted to make a brief comment and pose a question to the minister.

I know this has been a very important bill as the Leader of the Liberal Party did attempt to deal with phosphorus in dishwasher soap. He had included in the bill both commercial and residential, from what I understand, and in Bill 8, I don't believe it was the intent of Bill 8 to deal with–or what's the government proposing to do with regard to commercial dishwasher soap?

Ms. Melnick: What we're looking at are locations where there might be heightened need for sanitation such as in restaurants, hospitals, and so that's what this bill is designed to accommodate. That's the exception that we would look at here.

There may also be exceptions in households where there's a particular health need. Perhaps a need whether it might be perhaps an allergy situation. A need for, again, heightened sanitation. So we will be looking at those as we go along.

I think it's important to recognize that this is the first bill of its kind in Canada. It is accompanied by about seven or eight that have either been passed or in the process of being passed in the United States and that we are looking at the legislation that has been passed and that has been put forward, and we are making sure that we are keeping to the standard that other pieces of legislation are as well.

We continue to work with the Canadian Consumer Speciality Products Association to make sure that they are recognizing the needs that may be covered under this bill as well as needs that may be beyond this bill, and, again, that's where we look at exceptions.

Mr. Lamoureux: Madam Chair, prior to its passage–because the minister's right in the sense that this will be the first bill that will ultimately be passed–I do want to express concern, as I know the Leader of the Liberal Party has done, in regard to that the bill could have done more in terms of dishwasher soap in particular, and just to express some disappointment that the government didn't see the merits of what the Liberal Party had proposed last year.

Thank you, Madam Chair.

Ms. Melnick: Again, as one peruses the bill, they can see that there is opportunity for inclusion. We heard a very positive response by Darren Praznik this evening. We heard a very positive response from a member of the dry cleaning community as well, so we've made sure that this bill can, in fact, be inclusive. We intend to continue to work with communities, to continue to work with industry, and continue to ensure that we are limiting the phosphorus load on Lake Winnipeg as well as other waterways in Manitoba.

Madam Chairperson: Further? No.

Preamble–pass; enacting clause–pass; title–pass. Bill be reported.

Thank you.

Bill 9–The Protection for Persons in Care Amendment Act

Madam Chairperson: Would the Minister of Health care to join us?

Okay, this is Bill 9, The Protection for Persons in Care Amendment Act.

Does the minister responsible for Bill 9 have an opening statement?

Hon. Theresa Oswald (Minister of Health): Very briefly, in light of the fact we did not have any presenters on this bill, I just remind the members that The Protection for Persons in Care Amendment Act, of course, serves to further protect the identity of a person who reports an abuse or who provides information in respect of a reported abuse. It will ensure that investigators and others engaged in the administration of the act cannot be required to disclose information that could reveal such a person's identity. It also clarifies the minister's authority to designate employees as investigators and to appoint other investigators as needed.

Madam Chairperson: We thank the minister.

Does the critic for the official opposition have an opening statement?

No statement. We thank you and move on to the clauses.

Shall clauses 1 through 3 pass?

An Honourable Member: On a point of order, Madam Chair.

Point of Order

Madam Chairperson: Mr. Goertzen.

Mr. Kelvin Goertzen (Steinbach): As a point of order, I wonder if the minister–I understand that some of my colleagues have some questions that are maybe more ranging on the bill than what would fit nicely into a section-by-section discussion. I wonder if the minister would entertain some global questions on the bill. I don't think it's our intention to push the midnight deadline by any stretch of imagination and then, I think, we can proceed more quickly through the clause by clause.

Ms. Oswald: Sure.

Madam Chairperson: Thank you. Please proceed with your questions.

*** * ***

Mr. Goertzen: I thank the minister for that indulgence.

I've asked the minister previously in briefings and otherwise just about the appointment of investigators. Certainly, the principle of the bill in allowing for the protection of privacy for an individual who reports abuse, I think we are in general agreement with. The question relates, though, in terms of how these investigators are appointed, who they might be, sort of the skills and qualifications they might have. I would like this–have the minister put that on the record. The reason I ask that is it's not a principle of law per se, but generally when an individual has a discretion built into some sort of a judicial or quasi-judicial function that they're performing, the degree of skill they're expected to have is increased.

***** (21:10)

For example, we have police officers here tonight who have tremendous discretion in their job. Even though they work under a number of provincial and federal laws, they have discretion where to apply them and whether or not to apply them. Here we're giving discretion to a investigator to determine whether or not they will or will not release information regarding the identity of an individual.

So I'm mostly concerned about who these investigators will be. Does the minister have some sort of notion in terms of the nature of these individuals and the skills they might bring to apply in their position?

Ms. Oswald: I think I'd like to address the second concept of what the member is raising first. He has raised this with me before, and I have gone back to seek clarification on this. While in a moment I'll address the nature of qualifications for those individuals, I can provide, I hope, some comfort to the member in that those individuals will not be solely relied upon to make a decision concerning disclosure or non-disclosure. The role of the investigator is just that; it's investigative in nature. But any decisions that come to bear on what will happen about identities of individuals or witnesses actually get made as part of a team. It's a managerial decision as far as the Protection for Persons in Care Office goes. So I know that the member has been concerned about one individual person exercising that discretion singularly. It would be a group conversation and a group decision that would come forward. So I hope that offers comfort.

Secondly, we know the Protection for Persons in Care Office, professional staff, abuse prevention consultants, certainly, are sought on the basis of what I would call rigorous criteria. We know that listings for these kinds of appointments ask for such things as a university degree in health care or social sciences. There's a request for those that have experience working with violence and abuse issues, particularly as they pertain to the abuse of the elderly: direct experience managing or investigating abuse cases is considered an asset in these cases; experience working in health-care settings is a preferred issue in seeking these individuals; knowledge of related legislation, like PHIA, The Freedom of Information Protection of Privacy Act and, of course, this act; demonstrated assessment, analytical conceptual identification and resolution skills required; training in conflict management and mediation considered an asset; and demonstrated excellent skills in communication and inter-personally.

So I would concur with what the member says about other professions, that have been in our discussion this evening, having requirements of them, and that would be no different for these individuals who would be doing investigating.

Mr. Goertzen: Now would those requirements, the minister elaborated on, be found in regulation as part

of this or this simply a directive that comes from the department?

Ms. Oswald: These will not appear in regulation. They're just job requirements as people for abuse prevention consultant positions are sought from the department, from the Protection for Persons in Care Office.

Mr. Goertzen: So, just for clarity, for myself, because I'm not a human resource expert, would these individuals–and often we see ads that say, preferred candidate would have these requirements or would have these qualifications. So all these individuals who get hired have a university degree and these other qualifications listed or those with preferred skills and abilities?

Ms. Oswald: Certainly, there are issues in this list where an item is required, like, a university degree is required, others where it is preferred or is an asset.

Mr. Goertzen: I appreciate that. That gives me a degree of comfort. The minister specifically says that there would be a team of individuals making the decision on disclosure. Can she indicate who other than the investigators, specifically, would be part of that team?

Ms. Oswald: So these determinations would be made, as I stated, with the managers of the office of Protections for Persons in Care in accordance with the investigators who have done the legwork and have done the interviewing. So it would be, you know, there would be the consistency of the manager in the office and the investigator who would gather the information that would come together to make these decisions concerning disclosure of information.

Mr. Goertzen: Just so it's on the record and, again, we've had discussion about privacy tonight in different forms, but can the minister indicate what sort of criteria she would expect these groups to be weighing when making a decision whether or not to disclose a person's identity who may have come forward with an allegation of abuse?

Ms. Oswald: Depending on the nature of the issue. If it's dealing with concerns about a FIPPA request, for example, it would–the consultation would certainly be in direct work with the department's access and privacy co-ordinator. If it's concerning, you know, law enforcement types of issues, certainly legal counsel would be involved. It would depend on the nature of the issue, but the spirit of the legislation itself is–and the amendments, too–is about ensuring that the best minds come around the table to come to a decision that would protect safety while at the same time affording information to come forward as appropriate.

Mr. Goertzen: Would there be any ability of an individual who was seeking this information–I know there's a court ability to go down–but if an individual simply wanted to have some sort of written reasons in terms of why an identity isn't being disclosed, would they have access to that? Any sort of written decision from that group?

Ms. Oswald: Just to make sure that I understand your question, can you clarify for me to whom you are referring in your question? You know, in the case of facilities, for example, they would receive written reports of investigations wherein there may be identities that are blacked out for the protection of individuals. I just want to make sure I'm understanding what you're asking.

Mr. Goertzen: I think you did understand the question. Thank you.

Mrs. Myrna Driedger (Charleswood): When the bill first came out, there were a number of undertakings that the minister of the day had agreed to and actually never followed through with the provision of information, and one of them was the qualifications of the investigators that the minister did indicate tonight. We had tried before to find out some of that information along with a lot of other pieces of information that had never come forward. I found that interesting to hear all of those qualifications and the expectations of the investigators. So around that, just looking at the office of the Protection of Persons in Care, we were told back then that there's a manager as well as three individuals who receive complaints and then 15 investigators. Is that still the setup of this office?

***** (21:20)

Ms. Oswald: Certainly, not having been privy to those discussions then, what I can tell you now is that there is a provision of three EFTs for the investigation, but, of course, those investigative spots are very much part-time in nature. So it may very well be that there are 15 individuals that comprise that allotment of staffing, but I would want to double-check that for the member and get back to her on that.

Mrs. Driedger: Just so the minister is aware that the information of 15 investigators came from the minister of the day in 2001 who brought forward this information, and 15 was the number that was used.

He had indicated, and I'm just referring back now to *Hansard* from all of those questions, he said they are all from outside of the Department of Health and they were going to be seconded on an as-needed basis.

Can the minister indicate now, because I see in the legislation that in fact these investigators are now employed it appears by the government under the minister, and I'd like the minister to clarify what exactly that means?

Ms. Oswald: Indeed, these individuals, as this legislation is amended, will be civil servants. That is true within the context of the department, but there is a provision in this legislation to also appoint "and others" that can be outside of the government as appropriate in cases where one may see a concern for government being perceived to be investigating itself. That would be an appropriate time for an outside person, an "other," to be appointed, but this would not be inconsistent with other acts or within the context of Conservation, for example, or in public health were government employees are also tasked in the role of investigators. So we really would be bringing them in-house in the context of these amendments but would have a provision for those cases where most appropriate, an "other" to be appointed outside.

Mrs. Driedger: Would these investigators actually do site visits, then, when they receive a complaint, or are they just going to call the nursing home, say they received a complaint, and just ask if it's been dealt with, or do they actually make site visits?

Ms. Oswald: Of course, these individuals will be tasked with assessing to see that the threshold for abuse that is laid out has been met so there are not any inappropriate accusations made. It's a very delicate issue, to be sure, but once, of course, that threshold has been met, individuals will go out and do a robust investigation to gather as much information as possible.

Mrs. Driedger: Somebody that is familiar with the Protection of Persons in Care has indicated to me that previously, independent investigators were experienced and also had no stake in the outcome other than they just wanted to do a good job and they were safeguarding the alleged victims. There is some concern right now that some of that objectivity and distance and possible conflicts of interest might be affected because now, rather than what people understand were independent investigators employed from outside the department, now they are coming within the department.

That has some perception problems in my view in terms of either trying to control information or being micromanaged. How does the minister intend to, I guess, work within those kinds of parameters?

Ms. Oswald: Well, I think the member raises an important issue about the importance of having individuals that are qualified and, indeed, experienced, taking care of these very, very sensitive cases where we're talking about the most vulnerable people requiring a fair and objective outside observer. By outside, of course, I mean outside of the context of the given situation of abuse. I feel strongly and confident that individuals, just as in the case of public health inspection, in the case of situations in the context of Conservation are, you know, very professional, you know, civil servants, employees that take their jobs very seriously and will do their utmost to ensure that people are cared for, to ensure that people are protected. In those cases where it could be perceived that that kind of objectivity would not be one hundred percent, you know, at the fore in this discussion, there is provision in this legislation to have an "other" person. But we do believe that in this context, these individuals that are tasked with some of the most important work that can be done will carry out that work in a highly professional manner.

Mrs. Driedger: Is the minister able to provide the number of reports to Protection of Persons in Care Office for the years 2006 and 2007? Would she happen to have that here tonight?

Ms. Oswald: Not at my fingertips, but I can endeavour to get that information for the member.

Mrs. Driedger: In 2001, there was a commitment by the Minister of Health then to be transparent with those numbers and to regularly report them. They've never been reported since then. Can the minister tell us what happened with that and if it might be her intention? It's not even put into annual reports, and I would think that at least this kind of information should at least make it into an annual report. Can the minister indicate what happened to those, you know, commitments that were made in 2001?

Ms. Oswald: Again, I will endeavour to research commitments made and, in fact, where that information does, or as the member is asserting, does not exist and endeavour to get back to the member. I have a hunch in the coming days, we're going to have

even more opportunity to discuss these things further in our Estimates and I'll endeavour to have that information for the member then.

Mrs. Driedger: Certainly, I appreciate that because the numbers of complaints that have been coming in year after year are certainly interesting numbers to look at. In '04, there were a total of 843 and in '05 it was over a thousand. So those numbers have gone up from '04 to '05, and those we got through FIPPAs, by the way.

So it would be interesting to see what '06 is and '07. I know that some of the reports then tend to be founded or unfounded, or there are different categories like below threshold, direct referral, et cetera, et cetera.

In order to have a better understanding, I guess, of what is happening and, certainly, we're hearing comments that there is increased elder abuse that is happening, and with the increasing elder population in Manitoba, this is certainly something that we need to be very, very aware of. You know, it's pretty alarming to see, say, in '05, 14 reports, which were found to be founded, of sexual abuse. That's troublesome. Or even 26 of financial abuse; 73 of physical abuse. Those were founded. Those are pretty staggering numbers when we look at our elderly people who are so vulnerable.

***** (21:30)

So I'm concerned that these numbers have not been made public and considering the minister of the day was very clear. We've got his statements here, and it was a very strong commitment that he was making that they would definitely be made public. I'm concerned that that wasn't followed through by him or subsequent ministers, and I guess I'm just putting it on the table for this minister to see if that transparency will be forthcoming under her. I appreciate that she's taking that into consideration.

Ms. Oswald: The member articulates quite rightly that any time we hear of one founded case of anyone that would be taking advantage of our people in care of a sexual nature, a financial nature, physical abuse, that's one case too many, and it's very distressing. Certainly, as I committed earlier, I will endeavour to do the research to find out the journey of those numbers and where they are. I cannot confirm or deny for the member right now about their existence in part or in whole in public. I need to do that research and I will say that quite honestly.

I can also say that on some level, a very small one, when we see an increase in reports, we can surmise, I believe, that people become aware of their rights and they become aware of the existence of the Protection for Persons in Care Office. Then they know that help is out there and that those complaints can be made, and on some level knowing that more of these incidences are not being swept under the rug, but are being reported and are being dealt with, we can take some small comfort from that. Better that we should have numbers that say zero because people are just getting their heads on straight and not taking advantage of those people who are the most vulnerable.

So I'll commit to the member to do that research and provide her with a response.

Mrs. Driedger: Just for the record, to make everybody's search a little bit easier because I'm sure everybody's going to be looking as to where I'm getting this information from. Tuesday, May 29, 2001, the former Minister of Health of the day said, and I quote, we are going to be publishing regular information, public information on this at this time, and he was referring to complaints. So that commitment was made. It was part of the initial development of this legislation. So I look forward to that coming to fruition.

Madam Chairperson: Clauses 1 through 3–pass; clauses 4 and 5–pass; clause 6–pass; enacting clause–pass; title–pass. Bill be reported.

Bill 11–The Optometry Amendment Act

Madam Chairperson: Does the minister responsible for Bill 11 have an opening statement?

Hon. Theresa Oswald (Minister of Health): No, Madam Chair, we've had a very good presentation earlier this evening that captures the importance of this bill going forward. So I suggest we proceed.

Madam Chairperson: We thank the minister.

Does the critic from the official opposition have an opening statement?

Mr. Kelvin Goertzen (Steinbach): Madam Chairperson, just briefly, we obviously support the legislation that was stated during presentations.

Again, I want to echo, though, my thanks for the Member for Charleswood (Mrs. Driedger) for her work on this legislation to pass. Also, the former Member for Ste. Rose, Mr. Glen Cummings, who we all remember and know as a gentleman in the

Legislature, also was a strong advocate for this legislation. While he's not with us here tonight, certainly his work in the Legislature continues to show up in a variety of different forms, and this is one of them. So, we're looking forward to proceeding with this legislation.

Madam Chairperson: We thank the member.

Clauses 1 and 2–pass; clauses 3 and 4–pass; clauses 5 and 6–pass; clauses 7 through 9–pass; clauses 10 and 11–pass.

Shall clause 12 pass?

Mr. David Faurschou (Portage la Prairie): This evening we had a presentation that showed us, that demonstrated quite clearly that we are one of the last jurisdictions to move forward in North America in this regard. Can the minister perhaps give us some indication as to how long it's going to take her department to prepare the regulations and when we can expect this legislation to be proclaimed?

Ms. Oswald: Certainly, we're going to be working in consultation with our partners, the optometrists, and there's also a medical advisory committee that's going to be in place. We know that all parties are ready and willing to get to work immediately, so our goal is to have it ready to go as soon as possible.

Mr. Faurschou: In regard to the question, during this presentation it was clearly evident how anxious optometrists are to see this legislation proclaimed. I would suggest that they will be quite responsive when the minister does call upon them to help her department provide for the regulations, and I would like to see this legislation passed and proclaimed very quickly.

Ms. Oswald: I would agree that parties involved would be very interested. It was interesting to note in the presentation that three jurisdictions in Canada had similar legislation 10 years ago, I think, when the former government was in power. One might ask the question as to why we didn't giddy-up back then, but certainly we're all going to work together to see this go forward and ensure that we get this work done as quickly as possible.

Mr. Goertzen: I just would say I know that the minister was sort of admonishing the former government for not getting it done in a year and a half. I wonder if she would then characterize her long delay of eight years.

Ms. Oswald: Thoughtful deliberation, I'd call it.

Mr. Goertzen: I half agree. I think it's more deliberation but wasn't so thoughtful.

Ms. Oswald: Well, Madam Chair, certainly I would say again that we want to work with the optometrists that have been excellent partners and, indeed, the ophthalmologists who, although not here tonight, certainly lend their support to their colleagues. We know that the Manitoba Medical Association has also had some concerns going forward, but have also come to the table in a very positive way. These discussions, of course, do take time; they do take negotiation; but what we see before us, of course, is a bill that will enable optometrists in Manitoba to have that scope of practice increased. We have a bill before us that's going to, particularly for rural Manitobans, enable them to have service, you know, in a more accessible way. We do believe that this is going to be a very positive development for the people of Manitoba and we look forward to putting the puck in the net.

Mr. Goertzen: Well, we do as well, and they have taken eight years to score that goal, but certainly we know the need for it because of the pressure that the health-care system is under right across the province and not just in rural Manitoba or in cities like Winnipeg or Brandon. But the one aspect, of course, is to provide optometrists with the professional ability to do what they're trained to do and to use the full extent of their training, but the other aspect to never lose sight of is the fact that this might take a degree of pressure off of many of our doctors who are overworked and overwhelmed and many who've left the province won't benefit from this particular–hundreds that have left the province over the last eight years won't benefit from this particular legislation. It may have taken eight years to score the goal but we're glad the puck is in the crease of the net.

Madam Chairperson: Clause 12–pass; enacting clause–pass; title–pass. Bill be reported.

***** (21:40)

Bill 12–The Securities Transfer Act

Madam Chairperson: We have Bill 12, The Securities Transfer Act.

Does the minister responsible for Bill 12 have an opening statement?

Hon. Greg Selinger (Minister of Finance): Dispense with that.

Madam Chairperson: Thank you, Mr. Minister.

Does the critic from the official opposition have an opening statement? No. Thank you.

Due to the size and structure of Bill 12, is it the will of the committee to consider the bill in blocks of clauses corresponding to its nine parts, with the understanding that we will stop at any particular clause or clauses where members may have comments, questions, or amendments to propose? *[Agreed]*

Part 1, pages 1 to 11: clauses 1 through 9–pass; Part 2, pages 12 to 33: clauses 10 through 55–pass; Part 3, pages 34 to 39: clauses 56 through 67–pass; Part 4, pages 40 to 45: clauses 68 through 85–pass; Part 5, pages 46 to 53: clauses 86 through 94–pass; Part 6, pages 54 to 62: clauses 95 through 105–pass; Part 7, pages 63 to 83: clauses 106 through 134–pass; Part 8, pages 84 to 90: clauses 135 through 137–pass.

Part 9, page 91: Shall clauses 138 and 139 pass?

Mr. Selinger: No. I have an amendment I'd like to propose for clause 139.

Madam Chairperson: Before we go to the amendment for 139, clause 138–pass.

Mr. Selinger: I'd like to propose

THAT Clause 139 of the Bill be replaced with the following:

Coming into force
139 This Act comes into force on the day it receives royal assent.

Madam Chairperson: It has been moved by the Honourable Mr. Selinger

THAT Clause 139 of the Bill be replaced with the following:

Coming into force
139 This Act comes into force on the day it receives royal assent.

The amendment is in order.

The floor is open for questions.

Mr. David Faurschou (Portage la Prairie): I do appreciate the minister bringing forward this particular amendment. It is very close to the one that I was about to propose. In fact, it looks identical with the exception of the person moving the amendment.

I do want to say that I appreciate the department's foresight in bringing forward this amendment, because the legal community is most anxious to see this legislation pass, as well as to recognize that this is vitally important to our legal infrastructure in the province of Manitoba.

Madam Chairperson: Is the committee ready for the question?

An Honourable Member: Question.

Madam Chairperson: The question before the committee is as follows:

THAT Clause 139 of the Bill be replaced with the following:

Coming into force
139 This Act comes into force on the day it receives royal assent.

Amendment–pass.

Clause 139, as amended–pass.

Mr. Faurschou: I just want to take this opportunity to thank the personnel at Legislative Counsel for their assistance in preparing the amendments we see here this evening.

Mr. Selinger: I think the Member for Portage la Prairie has it right. This is a very large bill. It's quite technical in nature, but it's actually quite significant in that it provides quite a bit of property rights to people and consumer protection with respect to all forms of securities. It might look like a boring bill, which it is, but it's actually quite important for people. It gives them a lot of protection they don't presently have, and it could be very significant in terms of preventing lots of problems for people in the marketplace these days.

Madam Chairperson: Table of contents–pass; enacting clause–pass; title–pass; Bill as amended be reported.

The hour being 9:47, what is the will of the committee?

Some Honourable Members: Committee rise.

Madam Chairperson: Committee rise.

COMMITTEE ROSE AT: 9:47 p.m.

WRITTEN SUBMISSIONS PRESENTED BUT NOT READ

Re: Bill 18, The Testing of Bodily Fluids and Disclosure Act

Dear Standing Committee Members:

Please find attached our written submission with respect to Bill 18 (*The Testing of Bodily Fluids and*

Disclosure Act). As this brief details, legislation that authorizes forced blood testing in certain instances of potential occupational or non-occupational exposure to HIV and certain other blood-borne infections represents an unjustified and unnecessary rights violation. Such legislation does not represent an appropriately balanced policy response to the issue. It offers limited benefits to exposed persons and violates human rights. We therefore strongly recommend that it not be passed.

In addition to the information provided in our submission, drafted as a general analysis of legislation authorizing forced testing for HIV, we would like to highlight some specific concerns with the text proposed in Bill 18. If the Committee decides to recommend that the bill be adopted, we recommend that the specific amendments outlined below be adopted in order to significantly improve the legislation by reducing the harmful impacts it would have.

1. Expedited Testing Orders, Clauses 4 through 6

The expedited testing orders process proposed in Bill 18 must be amended in order not to unnecessarily trample on the rights of source persons. A judicial hearing should be required for all applications in order to justify the infringement of constitutionally-protected rights. We therefore recommend that the expedited process be removed from the legislation altogether so that all applications would be given proper judicial scrutiny.

Furthermore, under Bill 18 as drafted, the applicant for an expedited testing order is not required to provide a physician's report that assesses the risks of infection from the specific exposure. Without this evidence, the judicial justice of the peace would not be able to ascertain the level of risk of transmission faced by the applicant. As we explain on page 7 of our submission, a significant exposure occurs when a bodily fluid capable of transmitting the virus comes into contact with tissue under the skin, a mucous membrane or non-intact skin. Factors that influence the risk of infection include the virus involved, the type of exposure, the amount of blood involved in the exposure, and the amount of virus in the source person's blood at the time of the exposure. Only a medical professional who has met with the applicant after the applicant came into contact with the bodily fluid is able to make an accurate assessment of the risk of infection. A judicial justice of the peace does not have the expertise to make medical risk assessments.

If applications are being made without supporting evidence from a physician, there is also a very real risk that the applicants themselves may be unnecessarily worried about the risk of transmission because they have not been properly assessed and counselled by a physician. The expedited testing process invites applications from emergency responders, "Good Samaritans" and victims of crime who may not be at any real risk of infection, thereby potentially subjecting them to unnecessary anxiety and judicial processes. At the same time, source persons could be subjected to medical tests and disclosure of personal information in circumstances where there is no risk of transmission and hence no justification whatsoever for the testing order. We therefore recommend that, at a minimum, a physician's report be required with every application for testing, whether under an expedited or standard process. The physician's report should provide an assessment of the risk of transmission, based on a consultation with the exposed person.

In addition, as Bill 18 currently reads, the judicial justice of the peace can make an order for a test without having seen the documents adduced as evidence (clause 5(3)). Again, in order for the judicial justice of the peace to make an informed decision, he or she needs an opportunity to review all of the evidence. We therefore recommend that clause 5(3) be removed from the Bill and that applicant be required to transmit all of the documents before an order can be made.

Finally, as drafted the Bill does not appropriately circumscribe the circumstances when a testing order can be made. Unless a significant exposure has occurred, there is no reason whatsoever to issue a testing order. As we explain at page 6-7 of our submission, a significant exposure involves only certain bodily fluids and requires that the bodily fluid enter the exposed person's body through a percutaneous exposure, a mucocutaneous exposure or through non-intact skin. Mere contact with a bodily fluid does not put an emergency responder, "Good Samaritan" or victim of crime at risk. We therefore recommend that clause 6(1) be amended to read:

A judicial justice of the peace may make an expedited testing order if he or she is satisfied, based on the evidence adduced

a) that the applicant suffered a significant exposure to blood or another bodily fluid

capable to transmitting a communicable disease;

b) based on criteria prescribed by regulation, that the specific nature of the applicant's contact with the bodily fluid involved a significant risk of exposure to a micro-organism or pathogen causing a communicable disease;

c) that the information to be obtained from the proposed testing order cannot reasonably be obtained in any other manner; and

d) that a testing order would provide information that would enable the applicant to take measures to decrease or eliminate the risk to his or her health as a result of the exposure which he or she could not take in the absence of that information.

2. Notices of Objection to Testing Orders, Clause 7

In an appropriately balanced process that gives real protection to the rights of the source person, the source person must be given a meaningful opportunity to participate in the process and object to being forced to undergo medical tests. As drafted, the expedited process does not contemplate any participation by the source person. We recommend that the source person be permitted to testify and/or present his or her own evidence to the judicial justice of the peace if so desired, before an order can be issued.

The Bill does allow a source person to register an objection to the order, but only within 24 hours after the order has been served, unless otherwise specified in the order (clause 7). Twenty-four hours is a very short period of time, especially considering that the source person will often be ill and/or injured or have recently suffered a personal trauma, and will likely need to seek at least basic legal advice about his or her rights upon being served with such an order. In order for the right to object to be meaningful, we recommend that the time period be substantially increased. Furthermore, we recommend that exceptions be permitted if the source person could not reasonably register their objection within the specified time period.

3. Grounds on which a Source Person can Oppose a Testing Order, Clauses 12(4) & 13(2)

The unbalanced nature of the approach put forward with this legislation is further evidenced by the extremely limited grounds on which a source person can oppose a testing order. While the standard is set very low for the applicant seeking the order – they came into contact with a bodily fluid of the source individual and the contact involved a risk of exposure (clause 6(1)) – the standard is set very high for the source person who does not consent to testing. As drafted, only if the source person satisfies the court that taking the sample "would pose a significant risk to his or her physical or mental health" based on medical evidence, is the court instructed not to issue an order (clause 12(4)).

HIV testing can lead to a variety of negative consequences in a person's life, ranging from discrimination in housing and employment to ostracism from one's friends or family. Women may be at a particular risk of domestic violence if an abusive partner finds out about her HIV-positive status. It is precisely because of the complex social consequences of HIV, in addition to the seriousness of the medical condition, that informed *consent*, appropriate pre- and post-test *counselling*, and *confidentiality* of test results are the core principles of a human rights-based approach to HIV testing (see page 5-6 of our submission for a discussion of the "3 Cs" approach). There are many good reasons why a person might not consent to HIV testing at a particular time or in particular circumstances. It is therefore imperative that source persons be able to oppose a testing order on much broader grounds than those contained in the bill as drafted. We recommend that clause 12(4) and 13(2) be amended to include that the court has been satisfied that compulsory HIV testing would pose either a risk to the source person's physical or mental health, undue mental anguish, or the source person has a reasonable apprehension of harm.

4. Confidentiality and Disclosure of Test Results, Clauses 17-19

The right to privacy is protected by the *Canadian Charter of Rights and Freedoms* and is a central element of ethical medical practice. Legislation that authorizes forced testing and the disclosure of test results is by its very nature antithetical to confidentiality for the source person and potentially also for the exposed person. The source person's test results are disclosed to the exposed person and/or the exposed person's physician, and if HIV-positive then also to the medical officer of health. As we discuss on page 22-23 of our submission, once the source person's HIV status is known it can be used as evidence in court proceedings, it is likely that the exposed person will

discuss it with their family, friends and co-workers, and reporting on any court proceedings regarding the application can lead to it being publically revealed by the media.

Practically, there is little that can be done in legislation that would offer meaningful confidentiality protection for a source person. At a minimum however, we recommend that the clause 19(2)(iv) (which allows additional circumstances where disclosure is permitted to be added by regulation) be removed from the legislation, confidentiality guarantees be included in the testing orders, and that penalties for contravening provisions of the Act clearly apply to those who breach confidentiality.

5. Offence and Penalty, Clause 20

The Bill includes the possibility of either a fine or jail time as a penalty for breaching a provision of the proposed legislation. At six months in prison or $10,000 per day, with no maximum, we submit that the penalties are inordinately stiff and could amount to cruel and unusual punishment, particularly since this is not a serious criminal or quasi-criminal offence. We therefore recommend that the penalty be lowered considerably and a reasonable maximum be included.

Providing Emergency Responders and Others Covered by Bill 18 with Meaningful Health and Safety Protections

As we detail in our submission, the compulsory testing and disclosure contemplated in this legislation offers those exposed few benefits (see pages 10-17). Any benefits to be gained from forced HIV testing are limited to the rare circumstances where there has been a significant exposure to the risk of infection, the source person is available to be tested, *and* the source person does not consent to testing. While the source person's serological test results can provide useful information for making decisions about post-exposure prophylaxes and measures to protect against secondary transmission, other information such as the risk factors of the source person, the nature and extent of the exposure, and the source person's treatment history if using antiretrovirals, is also helpful and does not require forced testing.

Some claim that the understandable anxiety experienced by emergency responders, "Good Samaritans" and victims of crime who come into contact with bodily fluids is alleviated by having access to the test results of the source person. It is difficult to see how access to such forced test results will yield any significant "peace of mind" if they are properly counselled with respect to how blood-borne pathogens are transmitted, the actual (minimal) risk of infection, and the limitations of the testing technologies (including the possibility of false positive test results, and of false negative results from testing done during the "window period" during which a person may be infected but still test negative).

While forced testing legislation does nothing to prevent exposure to HIV in the first place, and offers very limited benefits when exposures do occur, there are things that can be done by the Government of Manitoba which would truly help emergency responders, "Good Samaritans" and victims of crime. Firstly and most importantly, addressing the misinformation regarding how HIV and other blood-borne infections are transmitted would go a long way to alleviate anxiety and to prevent exposures generally. For example, while many paramedics, firefighters and police officers seem to be very anxious that they will be infected, in reality the risk of occupational transmission is exceedingly low (see pages 8-11 of our submission). Surely educating emergency responders of the true risks would considerably alleviate the generalized anxiety.

Secondly, in order to prevent exposures, all emergency responders should be provided with the best available protective equipment, including, as appropriate, gloves, goggles, masks, and safety-engineered needles. Moreover, ensuring that all emergency responders have reasonable working hours and facilities can help prevent accidental injuries such as needle-sticks. Training on how to sensitively deal with marginalized and potentially high-risk persons could help to limit confrontations that may result in exposures.

Thirdly, Manitoba has a comprehensive protocol and guidelines to manage occupational and other exposures to blood and body fluids. Dissemination of this protocol and ongoing training to ensure that it is well understood and implemented, together with free access to post-exposure prophylaxis treatment and comprehensive counselling and support, can really help anyone who has been exposed.

Finally, by funding research, education and services for people living with or affected by HIV/AIDS, as well as education and prevention campaigns targeted to different segments of the population of Manitoba, the Government of

Manitoba can have a much more tangible impact in terms of both preventing infections and reducing the stigma and discrimination associated with HIV and other communicable diseases.

In conclusion, we reiterate that Bill 18 (*The Testing of Bodily Fluids and Disclosure Act*) is an unjustified and unnecessary rights violation. It is based on a flawed approach that does not adequately respect and protect human rights, while ignoring other approaches that would better respect and fulfil the human rights of workers. We therefore encourage the Standing Committee to recommend against adopting the legislation, or in the alternative to incorporate the amendments recommended here in order to better tailor the legislation and minimize the harms it would cause.

Thank you for considering our submission.

Legislation to Authorize Forced Testing for HIV In the Event of Occupational Exposure: An Unjustified and Unnecessary Rights Violation

A submission to the Government of Manitoba

Introduction

The Canadian HIV/AIDS Legal Network ("Legal Network") understands that a bill that would authorize the forced testing of people for HIV and other diseases in some situations of possible occupational and nonoccupational exposure will be introduced in the Legislative Assembly of Manitoba in April 2008.

The Legal Network wishes to take this opportunity to comment on the proposed bill. The Legal Network supports measures to prevent the spread of HIV, including for workers such as police officers, firefighters, ambulance attendants, para-medics and those providing emergency assistance (collectively referred to as emergency responders in this submission) and health care workers. The Legal Network also supports access to quality HIV testing and counselling, and access to care, treatment and support for those who may be exposed to the risk of HIV infection, whether occupationally or otherwise. Finally, we support measures that respect and protect the rights of people living with HIV and those vulnerable to HIV infection.

However, legislation that authorizes compulsory blood testing is not a measure to prevent the spread of HIV, nor an example of quality HIV testing, counselling, care, treatment or support for those exposed to the risk of infection. Compulsory blood testing is not a measure that respects and protects the right of people living with or vulnerable to HIV infection. Therefore, this submission sets out our position as to why legislation authorizing the forced testing of people for HIV should not be enacted by Manitoba.

Legislation authorizing the forced testing of people for HIV (i.e., without a person's informed consent) does not represent an appropriately balanced policy response to the issue of occupational and non-occupational exposures to HIV. Forced testing legislation is a flawed approach that does not adequately respect and protect human rights. Occupational exposure to HIV is an example of a situation where a legal "quick fix" is not the best solution to a complex problem.

Workers who risk exposure to blood-borne pathogens such as the Hepatitis B and C viruses and HIV deserve a more considered, comprehensive response from legislators, a response that would help ensure the human right to safe and healthy working conditions is fulfilled, thereby offering real protections for such workers.[1] Moreover, ensuring access to adequate information, counselling, support and treatment in the event of an exposure is more beneficial to emergency responders than are the test results sought through this type of legislation. An approach that offers real HIV prevention and support, and protects the human rights of everyone involved represents a more constructive and useful alternative.

We note by way of background context for the submissions that follow, that Manitoba currently has a comprehensive protocol and guidelines to manage occupational and other exposures to blood and body fluids.[2] Notably, these guidelines state that all testing is to be voluntary and informed consent must be obtained prior to all testing, both for the exposed person and the source person.

---

[1] The right to just and favourable conditions of work, including safe and healthy working conditions, is set out in the *International Covenant on Economic, Social and Cultural Rights*, Article 7(b). Canada has ratified this treaty.

[2] *Integrated Post-Exposure Protocol: Guidelines for Managing Exposures to Blood/Body Fluids*. Manitoba. November 2003. Available at www.gov.mb.ca/health/publichealth/cdc/fs/ipep.pdf.

About the Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network (www.aidslaw.ca) is a national organization engaged in research, education and policy development on legal issues related to HIV/AIDS. The Legal Network promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally. We have over 100 members across Canada and around the world, many of whom are community-based organizations and AIDS service organizations.

The Legal Network has been involved in extensive government, community and international consultations regarding a diverse range of human rights and policy issue related to HIV/AIDS. HIV testing and disclosure issues have been a key aspect of the Legal Network's research and analysis for many years. This includes extensive work specifically on the issue of compulsory HIV testing. In 2001 we produced *Testing of Persons Believed to Be the Source of an Occupational Exposure to HBV, HCV, or HIV: A Backgrounder*.[3] In 2002, based on the *Backgrounder*, we produced *Occupational Exposure to HIV and Forced HIV Testing: Questions and Answers*.[4] In February 2002, the Legal Network appeared before the House of Commons Standing Committee on Justice and Human Rights on Bill C-217, the proposed "Blood Samples Act." We presented written and oral submissions highlighting the serious human rights issues raised by the legislation. On the Standing Committee's recommendation, the Bill did not proceed. In 2007, we produced a booklet entitled *Undue Force: An Overview of Provincial Legislation on Forced Testing and HIV* examining the existing or pending legislation allowing for forced testing for blood-borne diseases in Ontario, Alberta, Nova Scotia, Saskatchewan and Manitoba.[5]

1. HIV Testing: the "3 Cs"

Both globally and within Canada, human rights-based responses to HIV/AIDS have been broadly endorsed.[6] Practically speaking, this means that human rights principles and protections should be at the heart of all policy decisions related to HIV testing. The "3 Cs" approach has become the accepted rights-based approach to HIV testing, shown to be effective[7] and endorsed by the United Nations.[8] The principles of the "3 Cs" approach are:

- HIV testing may only occur with specific informed consent voluntarily given. This requirement derives from the human right to security of the person[9] – that is, being able to control what happens to one's body – as well as from the right to information[10] that is an integral part of the right to health.
- Pre- and post-test counselling of good quality must be provided with every HIV test. This counselling gives effect to the right to information and is essential for both promoting the mental health of persons getting tested and protecting public health more broadly by helping to prevent onward transmission of HIV. Good quality counselling is of particular importance for people who may not otherwise get appropriate information on HIV/AIDS.
- Confidentiality of HIV test results, and even of the fact that someone has sought to be tested, must be protected. The

[3] T de Bruyn. *Testing of Persons Believed to Be the Source of an Occupational Exposure to HBV, HCV or HIV: A Backgrounder*. Canadian HIV/AIDS Legal Network. 2001. Unless otherwise indicated, data and studies referenced in this brief are drawn from that document. Please refer to the *Backgrounder* for citations to the original sources. The *Backgrounder* is available on-line via www.aidslaw.ca/testing. Please note that French versions of Legal Network documents regarding HIV testing are available via www.aidslaw.ca/test.

[4] T de Bruyn. *Occupational Exposure to HIV and forced HIV Testing: Questions and Answers*. Canadian HIV/AIDS Legal Network. 2001. Available via www.aidslaw.ca/testing.

[5] Available via www.aidslaw.ca/testing.

[6] E.g., see *Leading Together: Canada Takes Action on HIV/AIDS (2005/2010)*. Ottawa: Canadian Public Health Association, 2005; *International Guidelines on HIV/AIDS and Human Rights*, 2006 Consolidated Version. Geneva: UNAIDS & Office of the UN High Commissioner for Human Rights, 2006.

[7] The Voluntary HIV-1 Counseling and Testing Efficacy Study Group, "Efficacy of voluntary HIV-1 counselling and testing in individuals and couples in Kenya, Tanzania and Trinidad: a randomised trial," *Lancet* 2000: 356: 103-12.

[8] UNAIDS/WHO Policy Statement on HIV Testing (Geneva, June 2004).

[9] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11, at s.7; *International Covenant on Civil and Political Rights*, 999 U.N.T.S. 171, Article 9 [ICCPR].

[10] ICCPR, Article 19.

> confidentiality of medical tests derives from the right to privacy[11] and is a central element of ethical medical practice.

Compulsory testing is directly antithetical to the spirit of the rights-based approach embodied by the "3 Cs" approach to testing. Informed, voluntary consent is essential. Moreover, the right to be free of discrimination and the right to security of the person, in our view, require that in setting HIV testing policy governments must take into account the outcomes of HIV testing for people — including stigma, discrimination, violence and other abuse — and take steps to prevent human rights violations associated with this health service.

Under Canadian and international law, any public health action by the state that limits human rights must be justified by demonstrating that it is rationally connected to achieving a pressing objective, infringes rights as little as possible, and that the benefit must be proportional to the harm done to individuals' human rights.[12] It is our submission that legislation authorizing forced HIV testing would not pass this test, and as shall be demonstrated below, it is unnecessary in order to offer appropriate protections to emergency workers risking exposure to blood-borne pathogens in the course of their duties. Forced blood testing legislation as proposed in Manitoba therefore represents an unjustified and unnecessary violation to human rights and should not be adopted.

2. Risks and management of occupational exposures

It has become apparent over the years — including in testimony before the House of Commons Standing Committee that ultimately recommended against proceeding with forced testing legislation at the federal level — that there remains a great deal of misinformation about HIV, the risks of transmission through occupational exposures, and what should be done in the event of such exposures. Too often, such misinformation fuels calls for ill-conceived responses such as legislation authorizing forced testing for HIV and other blood-borne pathogens such as the Hepatitis B and C viruses.

A proper understanding of the basic facts is vital when considering whether such proposals are warranted or justified. Legislation should be informed both by a commitment to respecting and protecting human rights and by the best available medical and scientific evidence. To that end, in this section we provide an overview of the transmission risks and post-exposure treatments for the three blood-borne pathogens of primary concern – HIV, the Hepatitis B virus (HBV) and the Hepatitis C virus (HCV).

Significant exposure to HBV, HVC or HIV occurs when a body fluid capable of transmitting the virus comes into contact with:

- tissue under the skin (e.g., through a needle stick or cut), which is called a percutaneous exposure; .
- mucous membranes (e.g., through a splash to the eyes, nose or mouth), which is called a mucocutaneous exposures; and.
- non-intact skin (e.g., skin that is chapped, scraped or afflicted with dermatitis).

Contact with skin or clothing is not a significant exposure.

The types of body fluids capable of transmitting HBV, HVC and HIV include:

- blood, serum, plasma, and all biological fluids visibly contaminated with blood; .
- laboratory specimens, samples or cultures that contain concentrated HBV,
- HVC or HIV; .
- organ and tissue transplants;.
- breast milk; .
- pleural, amniotic, pericardial, synovial and cerebrospinal fluid; .
- uterine/vaginal secretions and semen; and.
- saliva (saliva on its own may transmit only HBV; if saliva is contaminated by blood, it may also transmit HCV and HIV).

---

[11] *Canadian Charter of Rights and Freedoms*, ss. 7 and 8; ICCPR, Article 17.

[12] R. v. *Oakes*, [1986] 1 SCR 103; *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, UN Doc. E/CN.4/1985/4, Annex (1985).

HBV, HCV and HIV are *not* transmitted by feces, nasal secretions, sputum, tears, urine or vomit, unless they are visibly contaminated by blood.

The factors that influence the risk of infection from a single exposure include:

- the virus involved; .
- the type of exposure;.
- the amount of blood involved in the exposure; and.
- the amount of the virus in the source person's blood at the time of
- exposure (the amount of HIV in the blood is higher in the initial stage of HIV infection and in the final stage of AIDS).

Injuries that are deep, involve a device that is visibly contaminated with the source person's blood, involve a needle that has been placed in the source person's vein or artery, and involve a source person with terminal illness are associated with a higher risk of HIV transmission in health-care workers suffering occupational percutaneous exposure to HIV-infected blood.[13]

2.1 HIV

Risk of transmission

Almost all available data on the risks of occupational transmission of HIV comes from exposures in health-care settings. The US Centers for Disease Control and Prevention (CDC) and the BC Centre for Excellence in HIV/AIDS have estimated that the risk of infection from a single *percutaneous* exposure to HIV-infected blood is 0.3% (1 in 300). In other words, there is a 99.7% probability that any such exposures will not lead to infection. This kind of direct, under-the-skin exposure to contaminated blood presents the greatest risk of transmitting HIV, and even then this is very low risk.

The risk of infection is lower for *mucotaneous* exposures to HIV-infected blood, at about 0.1% (1 in 1000). If the HIV-positive source person is taking anti-retroviral drugs, the chance of infection is lowered further because the drugs reduce the amount of virus in their blood (even to the point where the virus is clinically undetectable). If the HIV status of the source person is unknown, statistically the chance of infection from any exposure is even lower still.

Given these very low risks, it is not surprising that there have been only two probable cases, and only one definite case, of occupational transmission of HIV in Canada since the beginning of the epidemic.

The two probable cases involved laboratory workers working with contaminated blood, one in the early 1980s (before HIV was identified) and one working with cultured virus during research activities. The definite case was that of a health-care worker not wearing gloves who sustained a puncture wound involving a patient in the late stage of AIDS (when body fluids have elevated concentrations of HIV) and who did not seek post-exposure treatment with anti-retrovirals. Given the availability of protective devices (e.g., gloves, safety-engineered needles) and the procedures set out in Manitoba's *Integrated Post-Exposure Protocol*, occupation exposures such as these are not common or typical of those that occur today.

There is little data on occupational exposures among emergency responders (e.g., firefighters, ambulance attendants, police and correctional staff). The Chief Medical Officer of Health for Ontario, however, told a committee of that province's legislature that there have been no documented cases of "emergency services workers" (meaning police officers, firefighters and ambulance attendants) acquiring blood-borne pathogens occupationally in Ontario or in Canada.[14]

Post-exposure treatment

Following an occupational exposure to HIV, if *post-exposure prophylaxis* (sometimes referred to as PEP) is indicated in order to reduce the risk of infection, it will consist of treatment with two or three anti-retroviral drugs for a recommended period

[13] DM Cardo et al., A case-control study of HIV seroconversion in health care workers after percutaneous exposure. *New England Journal of Medicine* 1997: 337(21): 1485-1490 at 1487.

[14] Dr Colin D'Cunha, Chief Medical Officer of Health for Ontario. Submission to the Standing Committee on Justice and Social Policy, Legislature of Ontario, 4 December 2001.

of 4 weeks.[15] The degree of risk incurred in the exposure determines whether or not post-exposure prophylaxis is appropriate.

According to Manitoba's *Integrated Post-Exposure Protocol,* PEP is only appropriate where a "significant exposure" has occurred *and* the source person is known to be HIV-positive or the HIV-status of the source person is unknown and other risk factors are present. A "significant exposure" is defined as "an injury during which one person's blood or other high-risk body fluid comes into contact with another person's body cavity; subcutaneous tissue; or non-intact, chapped, or abraded skin or mucous membrane."[16]

For maximum effectiveness, post-exposure prophylaxis should be initiated as soon as possible after exposure, and ideally within 2 to 4 hours according to Manitoba's *Integrated Post-Exposure Protocol*.[17] Animal studies suggest that post-exposure prophylaxis probably is substantially less effective when started more than 24 to 36 hours following the exposure. Available data indicate that post-exposure prophylaxis for humans exposed in non-occupational settings is less likely to be effective if initiated 72 hours or later post-exposure.[18]

There are side effects for roughly three-quarters of those taking post-exposure prophylaxis. The most common are nausea, malaise or fatigue, headache, vomiting and diarrhea. These symptoms can often be managed with anti-nausea or anti-diarrhoea medications, or by modifying the dose interval (i.e., administer a lower dose more frequently). However, not all side effects can be adequately mitigated and they may result in time off work for individuals taking PEP. Side effects are also a principal reason for not completing the full course of post-exposure prophylaxis. Adverse side effects usually cease when treatment is stopped.

2.2 Hepatitis B

Risks of transmission

A preventive vaccine for HBV is available and those vaccinated are at virtually no risk of infection. All emergency responders and health care workers should be offered this vaccine as a truly effective protection against the occupational hazard of HBV infection, and removing any need for even contemplating forced testing for HBV following a possible exposure. Many members of the general public have also received this vaccine or have developed a natural immunity to HBV as result of exposure.

Post-exposure treatment

If the exposed person has not been vaccinated against HBV, the post-exposure prophylaxis will consist of hepatitis B vaccine and possibly hepatitis B immune globulin (HBIG). HBV vaccination is safe and reports of any serious adverse effects resulting receiving HBIG have been rare.[19] Vaccination helps prevent HBV infection in the exposed person and also protects against infection in the event of future exposures.

2.3 Hepatitis C

Risk of transmission

There is no preventive vaccine for HCV. According to the US CDC's most recent guidelines on managing occupational exposures, however, HCV "is not transmitted efficiently through occupational exposures to blood."[20] The risk of infection from a single percutaneous exposure to HCV-infected blood (i.e., the occupational exposure with the highest degree of risk) is estimated to be 1.8%. The risk of infection following mucotaneous exposure to HCV-infected blood is not known exactly, but is believed to be very small.

Post-exposure treatment

There is no post-exposure prophylaxis for exposure to HCV.

---

[15] US Public Health Service (Centers for Disease Control and Prevention). Updated US Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV and HIV and Recommendations for Postexposure Prophylaxis. *MMWR* 2001; 50 (No. RR-11) (29 June 2001)
Available at www.cdc.gov/mmwr/PDF/RR/RR5011.pdf. [Hereinafter "CDC Guidelines"].

[16] *Integrated Post-Exposure Protocol: Guidelines for Managing Exposures to Blood/Body Fluids*, at s 2.

[17] Ibid. at s 11.2.

[18] US Public Health Service (Centers for Disease Control and Prevention). Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States. MMWR 2005; 54 (No. RR-2) (21 January 2005). Available a www.cdc.gov/mmwr/PDF/rr/rr5402.pdf

[19] Ibid. at 5.

[20] Ibid. at 6.

3. The limited benefits that compulsory testing legislation might offer to exposed persons

Forced testing legislation such as that being proposed in Manitoba is supposed to benefit people potentially exposed to HIV, HBV and HVC by providing information regarding the source person's HIV, HBV or HCV status. This information is said to benefit the exposed person because it can be used:

a) to inform the exposed person's decisions about post-exposure prophylaxis;

b) to inform the exposed person's decisions about precautions to prevent secondary transmission to others (e.g., sexual partners, breastfeeding infants); and

c) to alleviate anxiety about the possibility of infection.

Each of these is an important consideration. Persons who have been exposed to blood or other bodily fluids need accurate information and support in order to access their degree of risk, make appropriate decisions and deal with anxiety.

However, as will be discussed in this section, these purported benefits of forced testing are subject to important qualifications. These qualifications must be taken into account both in assessing the balance of benefits and harms that such legislation carries and in the interests of ensuring exposed persons are given the information they need.

3.1 The rare circumstances in which compulsory testing legislation would offer any potential benefit

First, it must be remembered that the benefits of legislation authorizing compulsory testing only exist in those circumstances where:

- there has been a *significant exposure* to the risk of infection;
- the source person is available to be tested; and
- the source person does not consent to testing.

Most of those who are likely to be occupationally exposed to HBV have likely already received a very effective preventive vaccine. This means there will be few cases in which an occupational exposure to HBV will carry any significant risk of the exposed person being infected. In the case of HCV and HIV, it would only be those cases where one person's blood or other high-risk bodily fluid (i.e., not saliva, sputum, urine, etc.) comes into contact with another person's bodily cavity, subcutaneous tissue, non-intact skin or mucous membrane that could be considered a significant exposure. It is therefore only a small subset of cases of occupational exposure where there might be a great enough concern about the risk of infection to even consider testing the source person.

Furthermore, it has been established that in the overwhelming majority of cases of occupational exposure, the source person consents to testing.[21] A study of exposures of US police officers, for example, reported that 94% of source persons consented to testing. The House of Commons Committee that examined Bill C-217 heard testimony from an Alberta physician specializing in infectious diseases that approximately 99% of source patients consent to being tested in cases of occupational exposures to health care workers in hospitals.[22] In the first six months of study by the Canadian Needle Stick Surveillance Network, 83% of known source persons agreed to be tested.[23] Finally, it has been reported that in one hospital in British Columbia with over 1,700 significant exposures, all but two source people agreed to be tested; in Ontario, none of 2,600 refused to be tested.[24]

It may well be that in some cases the source person refuses to be tested, but we submit that evidence of a significant problem should be required before we step onto the slippery slope of passing legislation that authorizes testing people for HIV

---

[21] This information was presented by various parties to the House of Commons Standing Committee on Justice and Human Rights with regard to Bill C-217, including by the Member of Parliament who introduced the bill. See: Hon. Chuck Strahl, Member of Parliament. Evidence to the House of Commons Standing Committee on Justice and Human Rights, 12 December 2001.

[22] Dr Steven Shafran, Professor of Medicine, Director of Infectious Diseases Division, University of Alberta Hospital. Evidence to the House of Commons Standing Committee on Justice and Human Rights, 14 June 2000.

[23] S Onno. Oral presentation at the 9th Annual Conference of the Canadian Association of Nurses in AIDS Care, 2001. For discussion, see *Backgrounder*, at 7.

[24] Dr Chris Archibald, Chief, Division of HIV/AIDS Epidemiology and Surveillance, Department of Health. Evidence to the House of Commons Standing Committee on Justice and Human Rights, 27 February 2002. Dr Archibald was testifying before the committee in relation to Bill C-217, the proposed federal "Blood Samples Act."

without their consent. Because the vast majority of source people agree to be tested when a significant exposure happens, in most cases of occupational exposure, forced testing legislation serves no purpose.

3.2 Making decisions about post-exposure prophylaxis

The source person's serological test result can provide useful information for making decisions about post-exposure prophylaxis and if available, this information should be taken into account. Other information such as risk factors of the source person, the nature and extent of the exposure, and the source person's treatment history using anti-retroviral drugs should also be taken into account when it is available.

HIV

A person occupationally exposed to HIV must make a decision as to whether to initiate post-exposure prophylaxis. Does testing a source person for HIV offer such a benefit to the exposed person's decision-making process (in the handful of cases where there has been a significant exposure and the source person does not consent to testing) that it justifies overriding the rights of the source person, with the attendant harms?

Current medical advice is that post-exposure prophylaxis for HIV should be initiated within a matter of hours after the exposure. It is unlikely that in such a short period of time it will be possible to comply with the procedural safeguards set out in the legislation (such as arranging a judicial hearing to obtain a warrant, a safeguard which is required to justify the infringement of a constitutionally-protected right in the circumstances),[25] provide appropriate pre- and post-test counselling to both the exposed person and the source person, draw a blood sample from the source person, and then deliver the test results.

Even if these test results can be obtained within a matter of a few hours through an extremely expedited process and the use of "rapid tests" on-site, testing the source person provides only some of the information needed to determine whether the exposed person is at risk of infection and should initiate post-exposure prophylaxis. With respect to rapid tests, it should also be noted that these are *screening* tests only – they *do not* provide the confirmed test results currently available using laboratory procedures that consist of repeated testing using different kinds of tests. Due to the possibility of both false negative and false positive results, it is recommended that all reactive rapid tests are followed-up by laboratory-based confirmatory testing.[26]

What is being proposed with this legislation is to authorize compulsory HIV testing when, in the short period of time during which it might be of any possible benefit, the information that would be available is only an unconfirmed screening test result. The exposed person is still confronted with decisions about post-exposure prophylaxis and anxiety about possible infection, without definitive information on which to rely.

Some people choose to discontinue post-exposure prophylaxis if the source person tests HIV-negative. While an HIV-negative test result provides some reassurance, it does not rule out the possibility that the source person (and by extension the exposed person) might still be HIV-infected. The source person might be within the "window period," having been infected but not yet registering as such on the test.[27] Advances in HIV testing technology have reduced the "window period" significantly, but it remains a reality.

The "window period" is particularly relevant if the source person has recently engaged in high-risk activities, such as sharing drug-injection equipment or having unprotected sex. If high-risk activities were known or suspected by the exposed emergency

[25] See e.g., *R v Dyment*, [1988] 2 SCR 417 at 438.

[26] Public Health Agency of Canada. "Point-of-Care HIV Testing Using Rapid HIV Test Kits: Guidance for Health Care Professionals," *Canada Communicable Disease Report*, 2007: 33S2, 1-22, at p. 6.

[27] For a description of different testing technologies available for HIV, HCV and HBV see N. Constantine, et al. HIV Antibody Assays, *HIV insite*, May 2006.
Available at: http://hivinsite.ucsf.edu/Insite?page=kb00&doc=kb-02-02-01. See also S Stramer et al. Detection of HIV-1 and HCV infections among anti-body negative blood donors by nucleic acid-amplification testing. *New England Journal of Medicine* 2004; 351(8): 760-768; J Barletta. Lowering the detection limits of HIV-1 viral load using real-time immuno-PCR for HIV-1 p24 antigen. *American Journal of Clinical Pathology* 2004; 122(1): 20-27; F Hecht et al. Use of laboratory tests and clinical symptoms for the identification of primary HIV infection. *AIDS* 2002; 16(8):1119-1129.

responder or health care worker — as might well be in some circumstances, such as the police officer stuck with a needle in the course of searching someone incident to their arrest — he or she would no doubt be concerned about possible infection. In these circumstances, concern about the possibility of a "false negative" test would be greatest and reliance on a rapid test result would seem most precarious.

HBV

Given the availability of a highly effective preventive vaccine, and post-exposure prophylaxis that carries no appreciable risk of harm, knowing the person's HBV status is not necessary for treatment decisions. Decisions regarding post-exposure prophylaxis, therefore, are not a compelling rationale for compulsory testing of the source person for HBV.

HCV

There is no preventive vaccine against HCV nor is there a known effective post-exposure prophylaxis. In the absence of such medical options, decisions regarding post-exposure prophylaxis cannot be a relevant consideration regarding testing the source person for HCV.

3.3 Preventing secondary transmission

HIV

Persons exposed to HIV should be counselled about safer sex practices and about advising their sexual partners of the potential risk of transmission, as well as counselled about avoiding other activities (e.g., sharing needles) that pose a risk of transmission. Women should avoid becoming pregnant until reasonably sure they are not infected (based on a negative HIV test result at 3 months or 6 months at the outside), and if already pregnant, should be advised of the use of anti-retroviral therapy and other interventions to effectively eliminate the chance of transmitting the virus to their child during gestation or labour/delivery. If relevant, women should also be counselled about the risks of breast-feeding and advised about feeding alternatives. All of these are temporary behaviour modifications and can be undertaken whether or not the source person's HIV status is known. Preventing secondary transmission, therefore, is not a compelling reason to allow forced testing of source persons.

HBV and HCV

A person exposed to blood infected with HCV or HBV need not take any special precautions to prevent secondary transmission during the follow-up period (such as modifying sexual practices or refraining from becoming pregnant). They should refrain from donating blood, plasma, organs, tissue or semen.[28] Knowing the source person's HCV or HBV status is not necessary for this. Preventing secondary transmission is, therefore, not a compelling rationale for compulsory testing of the source person for HCV or HBV.

3.4 Alleviating anxiety of the exposed person

A person who has experienced a significant occupational exposure to blood (and potentially blood-borne pathogens) will no doubt experience anxiety. This anxiety is likely to persist until he or she is outside the window period and has tested negative for HBV, HCV or HIV.[29]

The majority of people who become infected with HIV seroconvert within the first 3 months following exposure, and often within the first few weeks. Ninety-five percent will have seroconverted (that is, test HIV-antibody positive) within 6 months following exposure. Therefore, if the exposed person has not seroconverted by 3 months, or certainly by 6 months, following the exposure, the chances of seroconverting beyond that point are practically nil.

There is no question that receiving a source person's *negative* test results for any of HBV, HCV or HIV can relieve some of the anxiety of the exposed person (and their loved ones) about possible infection, as it means it is statistically less likely that they have been infected as a result of the exposure.[30] (Of course, as already noted, it is possible that the negative result is a false negative if the source person is in the window period before HIV is detectable by standard tests or if a rapid test produces a false negative result.)

---

[28] CDC Guidelines, at 23.

[29] Specific antibody to HIV is produced shortly after infection; the exact time depends on several factors including host and viral characteristics. Using early-generation HIV tests, HIV antibodies can be detected within 6 to 12 weeks after infection (the time period prior to tests being able to detect the antibodies is what is referred to as the "window period"). Some newer tests however are able to detect antibodies at about 3-4 weeks after infection. See N. Constantine, HIV Antibody Assays, note 27 above.

[30] In the case of the exposed person already vaccinated against HBV, providing adequate information to the exposed person about the effectiveness of the preventive vaccine should go some considerable distance toward alleviating concern following exposure, meaning the anxiety-alleviating value of knowing the source person's HBV test result is much less significant.

Knowledge of the source person's HIV test result may be a double-edged sword with respect to the anxiety felt by the exposed person as they wait for their own test results following an exposure. In cases where the source person tests *positive* for HIV, this information will only *increase* the exposed person's anxiety during the waiting period although they remain at a low chance of being infected (see above). The point is simply that, as with the other benefits said to flow from knowing the source person's status, the claimed benefit of alleviating anxiety is a qualified one.

Ensuring that appropriate counselling and information is provided to the exposed person is as important as testing in achieving the goal of relieving the exposed person's anxiety. Counselling can and should be done without resort to compulsory testing. Many exposed police officers, fire fighters, health care workers and good Samaritans believe that they are at much higher risk of infection than the circumstances of their exposure indicate, or do not fully understand window periods and what the test results mean. This misinformation is a tremendous source of anxiety to exposed persons and it is fully avoidable.

Access to accurate, quality information would indeed go a long way to relieve anxiety amongst those who have been potentially exposed to infection. That no emergency responders and exceedingly few health care workers (1 definite, 2 probable) have actually been infected with HIV in Canada through occupational exposure is the type of critical information that truly would relieve anxiety.

4. Compulsory testing legislation violates human rights

The qualified benefits offered by compulsory testing must be weighed against legal and ethical concerns based on values Canadian society considers important. In this regard, the Legal Network raises three concerns regarding the proposed compulsory testing legislation:

- the disregard for the ethical and legal principle of informed consent;
- unjustified infringements of Charter rights; and
- the inconsistency, from a public policy perspective, of imposing compulsory testing on source persons of emergency responders, and not *vice versa*.

4.1 The legal and ethical doctrine of informed consent

Forced testing violates the legal and ethical principle of informed consent.

The legal doctrine of informed consent reflects the fundamental principle of respect for persons and their autonomy. The Supreme Court of Canada has repeatedly recognized that a person cannot be subjected to medical procedures without his or her informed consent.[31] This requirement has also been codified into statute in many provinces and forms a part of the codes of ethical conduct for all health care professionals. Respect for persons — the ethical imperative — requires that each person is valued and treated as an end in himself or herself, not merely as means to the ends of other people.

In 1995, Health Canada convened a national conference that established a consensus on guidelines for a protocol to notify emergency responders when they may have been exposed to an infectious disease.[32] In 1996, Health Canada convened a meeting establishing a protocol for managing exposure to HBV, HCV and HIV among health-care workers.[33] Both reiterated that informed consent must be obtained for testing the source person.[34]

Manitoba's *Integrated Post-Exposure Protocol* emphasizes voluntary testing and the informed

---

[31] *Reibl v Hughes*, [1980] 2 SCR 990; see also: *Hopp v Lepp*, [1980] 2 SCR 192; *Ciarlello v Schacter*, [1993] 2 SCR 119; *Malette v Shulman* (1990), 37 OAC 281 (CA); *Fleming v Reid* (1991), 82 DLR (4th) 298 (Ont CA); *Videto v Kennedy* (1981), 33 OR (2d) 497 (CA).

[32] Health Canada. A national consensus on guidelines for establishment of a post-exposure notification protocol for emergency responders. *Canada Communicable Disease Report* 1995; 21(19): 169-175.

[33] Health Canada. An integrated protocol to manage health care workers exposed to bloodborne pathogens. *Canada Communicable Disease Report* 1997; 23 (Suppl 23S2): 1-14.

[34] A discussion paper written by ULCC member Prof. Wayne Renke argues that the Health Canada protocol is ineffective because its disclosure provisions are not broad enough to cover all cases of occupational exposure. However, this approach ignores the fact that Health Canada has rightly adopted an informed consent approach to situations of occupational exposure. See W Renke. *Communicable Disease Exposure and Privacy Limitations: Issues Paper*. Uniform Law Conference of Canada. 2003. Available via www.ulcc.ca.

consent, for both the exposed person and the source person.[35] Specifically, it states that:

Informed consent must be obtained prior to all testing. It may be given verbally rather than in writing, but this should be recorded. For the Source person, consent should include permission to make the test results available to the Exposed. The Exposed should not become involved in obtaining consent from the Source.[36]

Similarly, the Canadian Medical Association Code of Ethics advices physicians that "[i]f a service is recommended for the benefit of others, as for example in matters of public health, inform the patient of this fact and proceed only with explicit informed consent or where required by law."[37]

The qualified benefits of forced testing, examined above, are not sufficient to rationalize the serious legal and ethical violation that occurs when the requirement of informed consent for a medical procedure is set aside.

4.2 Human rights concerns under the Charter

Forced testing legislation raises numerous human rights concerns under the *Canadian Charter of Rights and Freedoms*. In our submission, the government violates the *Charter* if it authorizes HIV testing without consent. In particular, it infringes the rights to liberty and security of the person (section 7) and the right to be free from unreasonable seizure (section 8). A person's right to privacy is reflected in both of these constitutional guarantees.

We look at each of these considerations below. We then address the question of whether these infringements of constitutionally-guaranteed human rights can be justified.

<u>The rights to liberty and to security of the person</u>

First, forcibly subjecting a person to a medical procedure without his or her consent amounts to an infringement of his or her security of the person. To have your blood drawn against your express wishes represents the quintessential harm against which the *Charter* right is to provide some protection. If the state is to exercise its coercive power in this way to infringe basic human rights, it must have a strong justification for doing so. Under the *Charter* the state must show that a violation of the right to liberty or security of the person is consistent with the basic principles of our legal system and is demonstrably justified in our free and democratic society (see below the discussion of whether this violation of constitutional rights is justified).

Second, if the proposed legislation provides that a source person who refuses to comply with an order to provide a blood sample for testing is guilty of an offence, the legislation would criminalize people for asserting their legal right to bodily integrity and informed consent. Furthermore, if the legislation permits medical officers of health to enlist the aid of peace officers to compel testing in the face of a refusal to comply with the court's order, further infringements of both liberty and security of the person would ensue in forcibly detaining a person and drawing blood.

<u>The right to physical privacy also protects bodily and psychological integrity</u>

The Supreme Court ruled has ruled, in the *Dyment* case, that the use of a person's body without his consent to obtain information about him invades an area of personal privacy essential to the maintenance of human dignity... [T]he protection of the *Charter* extends to prevent a police officer, an agent of the state, from taking a substance as intimately personal as a person's blood from a person who holds it subject to a duty to respect the dignity and privacy of that person."[38]

In *Dyment*, police had obtained without patient's consent a sample of free-flowing (not drawn) blood obtained by a physician treating a man involved in an automobile accident. The Supreme Court ruled this was an unlawful seizure in breach of section 8 of the *Charter* and that the violation of the man's privacy interests were not minimal.

The Court had said previously in one of the leading cases on section 8 of the *Charter*,[39] and reiterated in *Dyment*, that the function of the *Charter* "is to provide…for the unremitting protection of individual rights and liberties" and that a major

[35] *Integrated Post-Exposure Protocol: Guidelines for Managing Exposures to Blood/Body Fluids*, at ss 6, 7, 11.

[36] Ibid., at s.7.

[37] *CMA Code of Ethics*, (Update 2004), para. 23.

[38] *R v Dyment*

[39] Hunter v. *Southam*, [1984] 2 SCR 145 at 155.

purpose of the constitutional protection against unreasonable search and seizure is the protection of the privacy of the individual. Furthermore, that right "must be interpreted in a broad and liberal manner so as to secure the citizen's right to a reasonable expectation of privacy against governmental encroachments."[40] The Supreme Court has since reiterated: "That physical integrity, including bodily fluids, ranks high among the matters receiving constitutional protection, there is no doubt…"[41]

There has been only one reported case in Canada directly considering the question of whether a court may order HIV testing of a person against his or her will, and provide the test results to a person claiming to have been exposed to a risk of infection.[42] In this case, a woman sought an order that the man accused of sexually assaulting her provide a blood sample for HIV testing.[43] The order was refused. The court, a Quebec trial court, expressly referred to the Supreme Court's decision in *Dyment* and noted that forced testing raises serious *Charter* concerns.

Taking bodily samples without consent is clearly the exception in Canadian law. Indeed, the *Criminal Code* only allows it in two carefully limited circumstances — that is, testing for alcohol when there are reasonable grounds to believe an offence of impaired driving has been committed and for the purpose of DNA analysis relating to a prosecution for certain designated serious offences. In both of those circumstances, the infringement of privacy has been deemed justified in the interests of law enforcement once reasonable grounds exist for believing a person has engaged in criminal wrongdoing.

Forced blood testing legislation such as that proposed for Manitoba would authorize medical tests on people without their consent, without any requirement that there be at least a *prima facie* case of wrongdoing. Compulsory testing could be ordered for a person who has not been arrested or charged with any criminal or quasi-criminal offence. Under this legislation, an accident victim found unconscious by the roadside could be ordered to be tested for HIV, HCV and/or HBV if an emergency responder had broken skin that came into contact with the victim's blood. Someone injured in a domestic assault could be compelled to be tested for these viruses if a healthcare worker accidentally stuck him or herself with a needle while treating her injuries. Any patient receiving health care services could be the subject of an order for compulsory testing.

The violation of physical privacy and bodily integrity is compounded by a violation of psychological integrity by removing for the source person the option to decide whether and when to get tested in accordance with their own personal circumstances.

Informational privacy

Two years after the *Dyment* decision, the Supreme Court ruled in the *Duarte* case that the *Charter* protects the right of an individual to determine for himself or herself when, how, and to what extent they will release personal information about themselves.[44]

It may be hard for many to imagine why someone might refuse testing. Indeed most people consent to testing in circumstances of occupational exposure, and knowing one's serostatus allows a person to access potentially lifesaving treatments and modify his or her behaviour so as not to infect others. But there are indeed good reasons why people do not wish to be tested. The loss of confidentiality about something as significant as HIV status can produce a whole range of negative consequences. Stigma and discrimination related to a disease like HIV/AIDS are a reality in Canada.[45] For example, discrimination in employment, services, accommodation and membership in social or professional associations persists for people known or perceived to be HIV-

[40] *Dyment*, at 426. In the earlier case of *R v Pohoretsky*, [1987] 1 SCR 945, the Court stressed the seriousness of a violation of the sanctity of a person's body as an affront to dignity.

[41] *R* v. *Colarusso*, [1994] 1 SCR 20 at 53.

[42] There have been other cases in which a request for a testing order has ultimately been agreed to by the accused (e.g., in the case of Paul Bernardo), so the issue of the constitutionality of forced HIV testing has not been judicially analysed in those cases.

[43] *R* c. *Beaulieu*, [1992] AB No. 2046 (Cour du Québec – Chambre criminelle).

[44] [1990] 1 SCR 30 at 46.

[45] See: (1) Series of info sheets on "HIV/AIDS and discrimination"; (2) T de Bruyn. *HIV/AIDS and Discrimination: Final Report*. Canadian HIV/AIDS Legal Network. 1998; (3) T de Bruyn. *A Plan of action for Canada to reduce HIV/AIDS-related stigma and discrimination*. Canadian HIV/AIDS Legal Network. 2004. All documents are available on-line via www.aidslaw.ca/discrimination.

positive (or to have hepatitis). A victim of domestic assault who tests HIV-positive faces the prospect that public health authorities would notify his or her partner of the partner's possible past exposure.

It is questionable whether the privacy protection afforded in forced testing legislation can ever be more than illusory.

First, evidence of someone's HIV-positive status can find its way into evidence in court proceedings. Once the source person's status is known, that information is compellable from them under oath in another proceeding. A province does not have the constitutional jurisdiction to declare evidence inadmissible in a criminal proceeding. Consequently, provincial legislation authorizing forced HIV testing could result in evidence that could be used against a source person in a criminal proceeding — a violation of the constitutional right against selfincrimination.[46] Such an outcome would compound the original violations of the source person's constitutional rights to liberty, security of the person and privacy (including the right to be free from unreasonable search and seizure).

Second, the very purpose of forced testing legislation is to inform an exposed person of the source person's serostatus. Requiring confidentially on the part of those carrying out responsibilities associated with the provisions of the legislation, such as the public health officer, peace officer, health care workers and analysis is of limited value. The source person's identity and HIV test result are communicated to the exposed person. Even if the law may state that the exposed person is not allowed to disclose this information to others, this is likely to be unenforceable in practice. One can understand the desire to share this information with family, friends and co-workers with whom the fact of the initial exposure has likely already been discussed. Those people may in turn discuss this information with others, with the result that the source person's HIV-positive status could become widely known. The invasion of the source person's privacy would be particularly acute in a smaller community. In reality, it is practically impossible to legislate any effective confidentiality protection for a source person who has been forcibly tested for HIV, just as the law will be able to do little to protect against HIV/AIDS-related stigma that will follow.

Two decades of experience show that breaches of confidentiality are commonly experienced by people living with HIV, particularly in small or closely knit communities, and that the consequences can be devastating. In most cases, there is no effective, accessible remedy.[47]

Prior judicial authorization dubious as a safeguard for *Charter* rights

Some of the forced testing legislation that exists in other jurisdictions includes a requirement of prior judicial authorization for compulsory testing orders. Certainly it is important that there be some such scrutiny of the legitimacy of the request before people are subjected to testing without their consent. Yet the safeguard of prior judicial authorization does not adequately protect every *Charter* right implicated.

The requirement of judicial authorization does not necessarily address concerns about the right to privacy. Experience to date indicates media interest in reporting cases of occupational HIV exposure of police officers and emergency responders. An application for compulsory testing would likely attract media attention and risks leading to the publication of the names or other identifying information about the source person in the course of reporting on the court proceeding.

Furthermore, some forced testing legislation contemplates that the requirement to notify the source person of an application for a testing order may be dispensed with in certain circumstances. This opens the door to an agent of the state (i.e., a court) issuing orders allowing for forced testing of people without giving them a chance to oppose the order.

Rights violations cannot be justified

In the leading *Oakes* case,[48] the Supreme Court of Canada set out the requirements for justifying legislation that infringes *Charter* rights under the provisions of section 1 of the *Charter*:

[46] The constitutional right against self-incrimination is based in sections 7, 11(c) and 13 of the *Charter*.

[47] See generally *Privacy Protection and the Disclosure of Health Information: Legal Issues for People Living with HIV/AIDS in Canada*. Montréal: Canadian HIV/AIDS Legal Network, 2002-2004. Available online via www.aidslaw.ca/privacy.

[48] *R v Oakes*, [1986] 1 SCR 103.

- the objective to be served by the measures infringing the right must relate to concerns that are "pressing and substantial in a "free and democratic society"; .
- the measures must be fair and not arbitrary, carefully designed to achieve the objective in question, and rationally connected to that objective;
- the measures should impair the Charter right as little as possible;

  and

- there must be proportionality between the effects of the limiting measure and the objective - the more severe the infringement of the right, the more important must be the objective.

We agree that protecting people against occupational and non-occupational exposures to blood-borne pathogens, and helping them deal with the aftermath of such an exposure, are pressing and substantial concerns. This is why the Legal Network supports, as a matter of workers' human rights, measures to prevent or reduce the risks of occupational exposures in the first place, and prompt and adequate information, counselling, support, accommodation and treatment in the event that exposures do occur. However, we submit that forced testing legislation such as that being proposed in Manitoba fails each of the remaining three steps required to justify a violation of *Charter* rights (i.e., the *Oakes* test under section 1 of the *Charter*).

Forced testing for blood-borne pathogens is not rationally connected to, nor does it achieve, the legislative objectives. After the fact testing for HIV, HBV or HCV does not protect against the occurrence of exposures involving emergency responders and health care workers. It does not make workplaces safer environments. Providing emergency responders and health care workers with a procedure to test a source person for HIV does not ensure that the source person's HIV status can be definitively determined during the time in which this information is crucial for making a decision about post-exposure prophylaxis (ideally within 2 to 4 hours).

As for addressing anxiety post-exposure, providing emergency responders with basic information about HIV transmission, accurate information about the risks involved in different types of exposures, and appropriate counselling resources would be more effective. Various leading associations of health professionals have criticized this sort of legislation as "not warranted" or "unjustified."[49] We have noted in detail above and in the *Backgrounder* that the rationale for authorizing compulsory testing for HCV and HBV is not borne out by the medical and scientific evidence. We submit that forced testing legislation impairs *Charter* rights in considerably more than a minimal fashion, for the reasons set out above, including:

- the application of physical force to conduct a medical procedure without consent; . the invasions of physical, psychological and informational privacy represented by compulsory testing;
- the practical impossibility of legislating adequate protection for the confidentiality of the test results of the person subject to compulsory testing, or of creating any effective remedy once the damage of testing without consent has been done;
- the potential negative ramifications that will or will likely follow for the person who tests positive (particularly for HIV) as a result of compulsory testing; and
- the viable alternatives for managing occupational (and non-occupational) exposures that seek to address many of the concerns and needs of exposed persons without infringing the constitutional rights of alleged source persons.

Finally, we submit that the requisite proportionality between objectives and infringement of *Charter* rights is not adequately demonstrated. Infringement of constitutional rights – liberty, security of the person, privacy (including freedom from unreasonable search and seizure), and possibly even the right against self-incrimination – is not warranted if it is unnecessary to achieve the legislative objectives. If the benefit to the exposed person is limited, and the potential negative

[49] As set out in the *Backgrounder*, at 25 to 31, the groups include Canadian Nurses Association, the Canadian Association of Nurses in AIDS Care, and the Canadian Medical Association.

consequences to the forcibly tested person are significant, compulsory testing legislation is not constitutionally justifiable. Workers who risk exposure to blood-borne pathogens such as the Hepatitis B and C viruses and HIV deserve a more considered, comprehensive response from legislators, which offers them real protection against infections to which they may be exposed. Ensuring access to adequate information, counselling, support and treatment in the event of an exposure is more beneficial to emergency responders and represents more a constructive and useful alternative.

4.3 Consistency in the law: an important policy consideration

Proposals such as the one being proposed in Manitoba also raise the issue of consistency in the law, which is desirable as a matter of public policy. This legislation would authorize the compulsory testing of a source person in the event that an emergency responder or health care worker is exposed in the course of their duties, and potentially if a Good Samaritan were exposed in the course of assisting another. But what if the emergency responder or health care worker exposes the other person to the risk of infection? The same rationales about obtaining information to make post-exposure prophylaxis decisions, prevent secondary transmission and alleviate anxiety would surely apply in those circumstances.

We are faced, then, with the prospect of authorizing the compulsory testing of emergency responders, health care workers and Good Samaritans — or, indeed, authorizing compulsory testing following any significant exposure of one person by another. This question was raised by representatives of Justice Canada before the House of Commons Standing Committee with respect to similar forced testing legislation, which legislation that Committee ultimately recommended not proceed.[50]

5. Conclusions and recommendations

Forced blood testing legislation, as is being proposed in Manitoba, offers few benefits to emergency responders and health care workers potentially exposed to HIV, HBV and/or HCV in the course of their duties, but raises serious constitutional concerns. As detailed in this submission, legislation of this sort is a flawed response to the real anxiety and health concerns of those potentially exposed to blood-borne infections. Misinformation about the true risks of infection and the limited benefit of test results compelled under legislation of this sort often motivate calls for legislation of this sort.

The rights of source persons deserve protection, and the very real negative consequences that can flow from compelled blood testing should give legislators pause when confronted with this bill. Testing source person's blood without consent, as contemplated in the forced testing legislation, is not a balanced, effective response to this issue.

Given the limited benefits and considerable risks posed by this policy approach, the Canadian HIV/AIDS Legal Network urges the Government of Manitoba and all parties in the Legislative Assembly not to adopt this legislation.

Richard Elliott
Canadian HIV/AIDS Legal Network

[50] Yvan Roy, Senior General Counsel, Criminal Law Policy Section, Justice Canada. Evidence to House of Commons Standing Committee on Justice and Human Rights, 13 June 2000.

The Legislative Assembly of Manitoba Debates and Proceedings
are also available on the Internet at the following address:

http://www.gov.mb.ca/legislature/hansard/index.html