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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1550)

[*English*]

The Vice-Chair (Ms. Marilyn Gladu (Sarnia—Lambton, CPC)): Good afternoon. Welcome to meeting 145 of the Standing Committee on Health. We're continuing our study of violence faced by health care workers.

We have a number of excellent people to testify with us today. From the Canadian Nurses Association, we have Josette Roussel, the Program Lead for Nursing Practice and Policy, and Isabelle St-Pierre, a registered nurse. As well, we have, from Concerned Ontario Doctors, Dr. Kulvinder Gill, the President.

[*Translation*]

From the Fédération interprofessionnelle de la santé du Québec, we welcome Linda Lapointe, who is its Vice-President, and Laurier Ouellet, who is President of the Syndicat des professionnelles en soins de Chaudière-Appalaches.

[*English*]

From the Ottawa Hospital, we have Thomas Hayes, the Director of Safety, Security, Parking and Staff Health in the HR department.

Each of you will have 10 minutes for your remarks. We'll begin with the Canadian Nurses Association.

Josette, you have 10 minutes.

Ms. Josette Roussel (Program Lead, Nursing Practice and Policy, Canadian Nurses Association): Thank you, Madam Chair and members of the committee, for the invitation.

My name is Josette Roussel. I'm a registered nurse and the Program Lead for Nursing Practice and Policy at the Canadian Nurses Association. I'm joined today by my colleague, Ms. Isabelle St-Pierre, who is a registered nurse and an associate professor at the Université du Québec en Outaouais. Ms. St-Pierre also has her doctorate in nursing, with a focus on horizontal workplace violence.

[*Translation*]

The Canadian Nurses Association is the national and international professional voice of nursing care in Canada. It represents more than 135,000 nurses in 13 provinces and territories of Canada.

The CNA advances the practice and profession of nursing in order to improve health outcomes and to reinforce the public and non-profit health system in Canada.

[*English*]

Canada's health care system couldn't function without nurses. Nurses work in a variety of settings, including hospitals, nursing homes, rehabilitation centres, clinics, community agencies, correctional services, long-term care and home care settings.

Violence in health care is not a new problem. Violence can be overt, such as physical, verbal, financial and sexual behaviours, or it can be covert, such as neglect, rudeness or humiliation in front of others. Violence can occur between employees of an organization, such as between nurses or between employees and non-employees, for example, between patients and nurses.

In fact, violence is a widely recognized global issue, with one-third of nurses worldwide being victims of physical assault, two-thirds being exposed to non-physical violence at work, and 80% being victims of some form of workplace violence. Although these numbers show an alarming situation, it is much worse. Only 19% of nurses formally report workplace violence.

Statistics show that 60% of new nurses who experienced workplace violence will resign from their first place of work within six months of employment, and of these nurses, 50% will choose to leave the profession altogether. Nurses are the most at risk of being attacked in their workplace, second to police officers.

While all nurses are at risk of workplace violence, we know that nurses working in long-term care, emergency departments and psychiatric settings may be more at risk, as well as night-shift workers and novice nurses.

Perpetrators of workplace violence include patients, and patients' families or visitors. They can be doctors, managers, other nurses or other employees. The work environment is also known to contribute to workplace violence. Examples of organizational factors that contribute to the problem include excessive workloads; inadequate staffing; excessive use of overtime, both mandatory and voluntary; lack of managerial support when reporting instances of workplace violence, and a lack of perceived consequence when committing violent acts.

Some of the most reported workplace violence consequences include physical injuries, post-traumatic disorders, burnout, anger management issues and persistent fear and anxiety, to name a few. Statistics from the Workplace Safety and Insurance Board in Ontario show that in 2016 lost-time injuries due to workplace violence in the health care sector greatly outnumbered those in other sectors, with over 800 injuries compared to manufacturing at 138, construction at three and mining at zero.

The effects of workplace violence in the health care sector are significant, and their consequences are real. Violence negatively affects outcomes for patients, nurses and organizations.

CNA has four recommendations to make to the committee.

The first is that the federal government lead a pan-Canadian strategy to study why workplace violence continues to be an issue and why initiatives continue to have limited success. This study may include conducting consultations, round tables, and a public inquiry seeking feedback from politicians, senior leaders, health care professionals, patients and families. This federal government study would also lead to clear, more targeted definitions of violence to move toward a common language to allow comparison of data.

The second is that the federal government create a hub for promising practices and create information-sharing opportunities for organizations to discuss best practices and learn from incidents and near misses.

Third, we recommend that the federal government support funding to evaluate existing programs and successful strategies and conduct a longitudinal research program on workplace violence. These evaluations should focus on learning from incidents and near misses, on what health care professionals say is effective in their organizations and on ensuring that policies have the intended on-the-ground outcomes.

Finally, we recommend that the federal government collaborate with provincial and territorial health ministries and health care organizations to develop prevention strategies to take into account individuals' characteristics, interpersonal factors and organizational factors. Such strategies could include, for example, minimum system enhancement initiatives related to health human resources, communications and work environments.

Along with these recommendations, I would also like to point out that part of the problem is that definitions of what constitutes workplace violence vary. Many words are used interchangeably and there is no one standard typology that classifies episodes of workplace violence. CNA's full submission to the committee will further outline the complexity of varying definitions. However, there is a need for more standardized language to describe the problem. There's also an ongoing debate as to whether intent should be considered as part of the definition as well.

In closing, with an upward trend in the number of incidents of workplace violence in health care, CNA believes that workplace violence requires immediate federal government action, including support for the victims. By adopting the recommendations made here today, the standing committee can address the growing need for prevention, evaluation and intervention pertaining to workplace violence in the health care sector.

It will take a sustained, concerted effort and collaboration if we are to achieve what we all want: violence-free workplaces and the resulting improvement in outcomes for patients, nurses and organizations. As well, because different factors contribute to violence perpetrated by patients' families or health care professionals, it will require different and multi-faceted strategies to alleviate it. It is not a simple one-size-fits all approach or solution.

I would again like to thank the committee for providing CNA with the opportunity to share our perspective and recommendations. Let's all work together to create a better future for our health care sector workers and nurses.

We look forward to your questions. Thank you.

● (1555)

The Vice-Chair (Ms. Marilyn Gladu): Absolutely.

Now we go to Concerned Ontario Doctors.

Dr. Gill, you have 10 minutes.

Dr. Kulvinder Gill (President, Concerned Ontario Doctors): Good afternoon.

I'm a front-line physician practising in Brampton and Milton, Ontario; a medical educator; and the co-founder and president of Concerned Ontario Doctors.

I thank you for the opportunity to address the Commons standing committee on health about your study into the violence faced by Canada's front-line physicians on behalf of Concerned Ontario Doctors, a grassroots, not-for-profit organization representing nearly 11,000 community and academic family physicians and specialists across Ontario. We advocate for a patient-centred, sustainable, accessible and high-quality health care system.

Canada's health care system was once a source of great pride for our country. It is unfathomable that we now rank third last for accessibility to patient care amongst all the wealthiest nations in the world. Ontario is in the midst of an historic health care crisis, with Ontario's doctors now into our eighth unprecedented year of billions of dollars in deep cuts to our essential front-line patient care, leaving more than one million patients in Ontario without a family doctor, creating province-wide emergency room gridlock, and causing wait times to explode, with some specialists' wait times rising to up to three years. Patients are increasingly projecting their frustrations and anger with the broken health care system onto front-line doctors.

The World Health Organization defines workplace violence as "the intentional use of physical force or power, threatened or actual, against another person or against...a group of people, that results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."

Health care is known to have the highest incidence of workplace violence. Ontario's nearly 29,000 physicians provide essential medical care to Ontario's 14 million citizens, with more than 300,000 patients cared for by Ontario's doctors every single day. It is crucial that governments address violence against front-line physicians in all aspects of front-line patient care delivery, from hospitals and long-term care homes to community clinics and home visits.

Canadian physicians working in hospitals and psychiatric ER departments and in after-hours clinics have an increased risk of encountering an abusive and violent patient, as do physicians making house calls and those who treat large numbers of patients with mental illness and addiction.

The majority of Ontario's front-line physicians face increased risks of violence in providing care in medical and walk-in clinics within the community. When de-escalation attempts fail, the only option that exists—often after the violence and abuse has already occurred—is for the front-line secretarial staff and doctors to call police. Front-line physicians have reported violence ranging from verbal abuse, racism and sexual harassment to physical violence, including patients spitting, biting, kicking, groping, punching, stabbing and assaulting physicians.

In a 2010 survey of Canada's family doctors, approximately one-third reported having endured aggressive behaviour from a patient or a patient's family member in the previous month. During their career, 98% reported at least one abusive incident. Of those, 75% were major incidents, such as sexual harassment, whereas nearly 40% were severe, such as sexual assault or stalking. The results varied for female physicians working on-call. Female physicians' sense of safety decreased dramatically to 7.2% during on-call duties, compared with male physicians at 75%. Of the physicians who experienced an abusive event in the previous month, 55% were not aware of any policies to protect them; 76% did not seek help, and 64% did not report the abusive event.

Physicians are increasingly experiencing cyberstalking and cyber-bullying by patients. In a recent Medscape survey of physicians in North America, nearly 40% of doctors reported online abuse. More patient hostility has been associated with online anonymity.

The National Academies of Sciences, Engineering and Medicine's 2018 report on women found, shockingly, that sexual harassment of women is most prevalent in medicine of all STEM fields, because in medicine, the harassers are colleagues, supervisors, staff and also patients. Four key factors were identified in the reports as creating higher levels of risk for sexual harassment in medicine. These included men having positions of power and authority, organizational tolerance of sexual harassment, hierarchal relationships, and isolating environments.

● (1600)

As many as 50% of female medical students report experiencing sexual harassment. Many research studies and reviews describe a culture of harassment in medicine, which has long-term implications for the profession, including significant reductions in professional, psychological and physical health. In Canada, most medical students are now women, and medicine now has a greater representation of people of colour within the profession than in the general population. However, women and people of colour occupy only a tiny fraction of leadership positions. It is the toxic culture within medicine that pushes women and people of colour out of leadership positions and that creates glass ceilings.

Violence against front-line physicians is associated with increased stress, burnout, addiction and risk of developing mental health illness, including depression, anxiety and suicidal ideation. It may also result in absences or refusal to work in high-risk areas and poorer patient outcomes. This is deeply concerning, as the burnout rate reported by Canada's nearly 87,000 physicians is now at 50%, and Ontario's physicians have a historic burnout rate of 63%.

Medicine has the highest suicide rate of any profession. This is an alarming public health crisis. The physician suicide rate is already more than twice that of the general population, with male doctors killing themselves at a rate that is 40% higher than of men in the general population, and female doctors killing themselves at a rate that is 130% higher than of women in general.

Ironically, physicians' provincial and territorial regulatory and licensing bodies do not recognize mental health and physical health as being equal. One of the greatest barriers to physicians receiving the mental health care they so desperately need remains mandatory reporting to provincial and territorial regulatory and licensing bodies. The majority of front-line physicians suffer in silence, fearing the implications for their medical licence and their livelihood of reporting.

Canada is entering uncharted territory, with our senior population projected to grow by 68% over the next 20 years. With our health care system already stretched well beyond its limits due to deep cuts and heavy rationing of front-line patient care, violence on the front lines of Canada's health care system will only escalate.

The Government of Canada has the opportunity to provide a strong leadership role in bringing collective change across provinces and territories. Concerned Ontario Doctors has 11 key recommendations.

One is a zero-tolerance policy toward workplace violence and harassment on the front lines of Canada's health care system.

Two is a universal definition of workplace violence.

Three is visible security and surveillance for workplace violence in hospitals, mental health facilities and long-term care homes, with formal reporting processes protecting against reprisals.

Four is development of comprehensive strategies to address the safety of physicians practising within community and walk-in clinics, providing home care visits and overnight on-call care, with formal reporting processes protecting against reprisals.

Five is that medical school and residency curriculums include mandatory training on approaches to de-escalation when encountering sexism, racism, harassment, verbal abuse and physical abuse from patients.

Six is that provincial and territorial medical regulatory and licensing colleges develop policies to address situations of sexism, racism, harassment, verbal abuse and physical abuse from patients against medical trainees and physicians and ensure that these policies are in line with the respective provincial-territorial human rights codes.

Seven is to ensure that front-line doctors have democratic representation that is accountable and transparent. According to OECD experts, harassment and corruption flourish and create a toxic environment when there is monopoly power. Ontario is unique in having a provincial medical association granted mandatory government-legislated dues from all physicians. That has created an untenable situation. Governments have a responsibility to protect patients and physicians, and to address toxicity and lack of democratic representation by repealing such legislation and undertaking an independent forensic review.

Eight is whistleblower legislation to protect physicians and all health care workers when they reporting wrongdoings impacting front-line and patient safety.

Nine is the creation of a front-line health care ombudsman, similar to that of other countries such as Australia, to allow for confidential reporting and to have a mandate to protect front-line workers.

● (1605)

Ten is that all levels of governments should address the alarming physician burnout and suicide epidemic.

Eleven is amendments to the Criminal Code to allow its provisions to apply to physicians, nurses and health care workers who are subjected to workplace violence, similar to those that already exist for transit workers and police officers.

Lastly, violence against front-line physicians, nurses and health care workers is a complex and multi-faceted societal problem that demands a comprehensive and multi-pronged approach, which is only possible with all of us working together.

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): Thanks very much. I'm sorry I'm late. I had a bit of a minor crisis.

Ms. Gladu, thank you for taking over.

Now we have the Fédération interprofessionnelle de la santé du Québec.

Ms. Lapointe, we are having technical difficulties with the video conference. We have no sound. We'll come back to you later.

We're going now to the Ottawa Hospital, with Thomas Hayes, director.

Mr. Thomas Hayes (Director, Safety, Security, Parking and Staff Health, Human Resources, The Ottawa Hospital): Thank you, Mr. Chair and committee members, for providing me the opportunity to speak to you today about workplace violence in health care.

My name is Thomas Hayes. I'm the Director of Safety, Security, Parking and Staff Health at The Ottawa Hospital. I've been at the hospital for over 16 years. We're one of Ontario's largest hospitals, with close to 16,000 staff, including 4,400 nurses, 1,400 physicians and midwives and 1,100 volunteers. We're a teaching hospital with thousands of students each year. We have 19 sites across the city of Ottawa. We see over 174,000 emergency visits a year and nearly 1.2 million ambulatory care visits, and last year, we delivered 6,211 babies. We have over 2,000 researchers and are ranked third in Canada for peer-reviewed funding from the Canadian Institutes of Health Research.

At the same time, last year we had 58 staff members who suffered injuries at work as a result of violence that was serious enough that they lost time from work or needed to see a physician. The security team at the hospital responded to an average of seven code white urgent physical interventions a day and three pre-emptive calls a day.

I want to acknowledge that violence in health care is a difficult topic to talk about. I want to tell you about two stories, and I've changed some of the aspects of these stories to protect the confidentiality of those involved

First, imagine you're a nurse. You're working in an emergency service. It's night. You have several patients being assessed and treated while they're being considered for admission, one of whom is with a visitor. It's been a long shift, and the security guard in your area asks if he can go get a coffee. You say, of course. Everything's quiet and everyone needs a break once in awhile.

Now you're alone. A few minutes pass and one of the patients under your care starts pacing the hall and trying to get into the rooms of the other patients. You go into the hall to speak to him, and he starts returning to his room.

The next thing you know, he's lunged at you, grabbing you, pulling your shirt over your head and punching you as you fall to the floor to protect yourself. The visitor, hearing the commotion, peers into the hallway, sees what's happening, goes back into the room and hits a panic button on the wall. Luckily, the security office is right across the hall from your area, and seconds later, four guards arrive and start to restrain the patient who's punching you, who by now seems to have lost interest in continuing to assault you. A nurse and a physician arrive to help as well, and you crawl to the locked nursing station to start to recover. What if that visitor hadn't been there? What if the visitor had left a few minutes earlier? You had no way of summoning assistance. There was no system or schedule in place to replace that guard who needed a break.

Fast forward a couple of years. You're a dialysis nurse working in the evening as several patients finish their day-long treatment. You know from your safety huddle earlier in the shift that one of the patients has exhibited violent and disruptive behaviour in past visits. Your manager had invited a safety officer and a member of the joint health and safety committee to provide a refresher on violence prevention training at your last team meeting and had encouraged people to report and to summon assistance when they needed it. They told you that this could happen anywhere in the hospital, not just in the emergency department or in mental health areas, and that, in fact, at one of the other campuses recently, a dialysis patient had come to his treatment with a large knife in his bag.

You notice that the patient is starting to get very upset with another nurse, who's trying to calm him down and lower his voice. You ask the clerk to call a code white, and you hear it paged overhead, calmly, almost right away. Less than a minute later, several security guards arrive, along with the overnight nursing supervisor. They check in with you, and together they approach the patient to discuss his concerns and are able to de-escalate the situation.

● (1610)

You provide a report in the safety learning system, where you're encouraged to report issues that relate to both staff and patient safety. The next day, your manager checks in with you after reading the report to make sure that you're okay. She thanks you for your action and lets you know she will be reviewing the incident with the violence prevention working group to see if there is anything else that can be learned from this event and shared with other departments.

At the Ottawa Hospital, we realized several years ago that we didn't really know how widespread violence against our staff members was and that it was much more serious than we thought. We decided that in order to achieve our vision to provide each patient with the world-class care, exceptional service and compassion we would want for our loved ones, we needed to provide that care and compassion to our staff as well. We expanded our corporate strategy to include a quadruple aim. Beyond better quality at lower cost, healthier populations and a better patient experience, it now includes a better staff experience. We have learned that through collaboration with labour groups like the Ontario Nurses' Association and our front-line staff, including physicians, we create a safer environment.

We know we still have a long way to go, like every other healthcare workplace, to address violence, but at least we feel more comfortable that our staff are not afraid to report issues so that they can be addressed in a way that respects the needs of patients, visitors and staff.

Thank you.

● (1615)

The Chair: Thank you very much.

Now we'll try again.

Madame Lapointe, please, go ahead for 10 minutes.

[*Translation*]

Ms. Linda Lapointe (Vice-President, Fédération interprofessionnelle de la santé du Québec): Good afternoon, committee members.

First, we want to thank you for this invitation and to tell you we feel it is extremely important for us to be involved in this study as you are addressing an essential issue for the 76,000 members of the Fédération interprofessionnelle de la santé du Québec.

My name is Linda Lapointe, and I am Vice-President of the FIQ and responsible for the occupational health a safety sector. We represent more than 90% of nurses, nursing assistants, respiratory therapists and clinical perfusionists in Quebec. Ninety per cent of our members are women, and they experience various forms of violence on a daily basis.

With me today is Laurier Ouellet, President of the Syndicat des professionnelles en soins de Chaudière-Appalaches. That union is affiliated with the FIQ and represents 3,500 nurses, nursing assistants and respiratory therapists in the region.

Health care professionals experience various forms of violence: physical, psychological, sexual and organizational. That violence may be active or passive, direct or indirect. We know that psychological violence is seven times more likely to occur than physical violence.

Specific information on health professionals is hard to come by because the available data cover all personnel in the social affairs sector. Consequently, it is difficult to form a clear picture of violence cases in the health care sector, particularly in long-term care facilities and in home care. In addition, as a result of underreporting—we'll come back to that later—the figures we're giving you today are merely the tip of the iceberg.

According to the statistics provided by the Commission des normes, de l'équité, de la santé et de la sécurité au travail, the CNESST, on violence, stress and harassment in the workplace, there was a 27% increase in accepted injury cases during the period from 2014 to 2017. Of those cases, 32% were attributable to physical violence and 12% to psychological violence. There was also an overall 11% increase in sexual and psychological harassment cases. Lastly, it was observed that women were involved in a large percentage of of those violence cases. For 2017 alone, the victims of 73% of injuries attributable to physical violence and 68% of those attributable to psychological violence were women.

The health sector alone accounts for 61% of accepted injury cases attributable to physical violence, although health personnel represent only 10% of the staff of all institutions covered by the commission. The number of accepted claims for injuries caused by violence in the workplace rose by nearly 25% between 2015 and 2017.

The consequences of violence are extremely serious and cause considerable pain and distress in the lives of health care professionals. Mr. Ouellet will explain this to you in greater detail.

Mr. Laurier Ouellet (President, Syndicat des professionnelles en soins de Chaudière-Appalaches, Fédération interprofessionnelle de la santé du Québec): Thank you.

I wanted to testify on the everyday conditions of violence experienced in the health sector at all facilities: long-term care centres, hospitals and even patients' homes. That violence is an omnipresent and everyday phenomenon. I am talking here about violence committed against patients in the form of threats, verbal attacks, blows, spitting, scratching and the like. This is the nature of our everyday work. In addition to the violence that certain patients exhibit as a result of the medical hierarchy and the lack of control that health care institutions such as mine have over doctors, unacceptable language, psychological harassment and contempt are factors that female workers deal with every day.

The media occasionally report the tragedy of pregnant women who lose unborn children as a result of violence suffered in the workplace. That's what happened to Ariel Garneau, who lost her unborn child as a result of a blow to the abdomen last winter. Even that kind of incident occurs every day, and when it happens to pregnant women, that violence is so intolerable it is referred to in those terms. It is not so clearly characterized in other instances. Very few measures are taken to prevent it. What's worse, our employers want pregnant women to stay on the job, in increasingly dangerous settings, even longer than was previously the case.

We feel our managers are not adequately held accountable. Staying on budget is the only thing that seems to count, regardless of the consequences for female workers.

This is a particularly insidious form of violence that is experienced in the health sector. It is organizational violence and appears to have two main causes: a sharp increase in workload as a result of budget cuts, and the medical hierarchy and its contempt for female health workers. Reporting is stifled by a conspiracy of silence and threats of punishment.

Organizational violence is a form of violence that causes stress, depression an illness. Many female workers are leaving the health sector. In a small region such as mine, work absences cost more than $40 million. That's enormous.

Female workers are forced to work mandatory overtime, even if they are physically and mentally exhausted, and even if it destroys their family lives. Every week, the union witnesses the tears, crises and distress experienced by female professionals who are required to work overtime under pressure and threats.

Female managers are aware of this violence. In many cases, they are former health professionals and experienced it themselves. The situation gradually tends to be downplayed, the violence is eventually viewed as trivial, no one really deals with the situation, and female health workers ultimately come to view violence as normal. In many cases, they don't even report the situation. The lack of time and excessive workloads also conspire to lower the reporting rate. In my region, we estimate that only 10% of cases are reported. Many factors still need to be understood and much remains to be done.

● (1620)

Ms. Linda Lapointe: Mr. Ouellet just referred to many of the factors that contribute to violence, such as excessive workloads and budget cuts. In addition, new public management tools have been introduced together with increasing numbers of performance indicators.

This obsession with efficiency dehumanizes the care provided and the impact on our health professionals. The series of reforms that have been made to the health system in Quebec has absorbed all vital energy and created even larger institutions. The result is a depleted, even exhausted, health sector in which violence levels are rising. These megastructures aren't conducive to proximity management.

Among these reforms, the deinstitutionalization of mental health patients makes it even more difficult to provide safe care. Teams travel to unsecure and unmonitored places to provide services such as in-home support. In addition, the closure of mental health emergency services doesn't reduce the number of patients.

The obstacles and risk factors are significant, and safeguards are inadequate to address their scope. However, we're convinced this is an issue for which every measure counts in building a culture of prevention.

First, FIC demands that the health sector be recognized as a priority group within the meaning of the Act respecting occupational health and safety. That measure would require employers to meet four obligations arising from the act: to establish a prevention program, to create a health program specific to an establishment, to strike an occupational health and safety committee and to designate a prevention representative.

In Quebec, with regard to psychological health, we can rely, in particular, on the provisions of the Act respecting labour standards. However, there is a gap between having a right and being able to exercise it.

We also have the National Standard for Psychological Health and Safety in the Workplace, which is an excellent tool, although its application is voluntary and not widespread.

We spoke about the increasing size of institutions, which creates a distance with managers. There is also a significant gap between the percentage of female care professionals and the number of women managers. In fact, 6% of health managers are men, although they form approximately 10% of the profession, and only 6% of managers are women, whereas they represent nearly 90% of the profession. The question should be why there are so few women in management. Could their presence there improve the situation regarding the violence our members experience?

For many years now, the federation has prioritized, and still prioritizes, action to establish new health professional-patient ratios. The state of knowledge, international experience and ratio projects introduced by FIQ confirm that sufficient numbers of health professionals can provide safe and more humane care. They can do it under an adequate workload in an environment conducive to their occupational health and safety.

The system must consider the needs of professionals to a greater degree, those of pregnant workers who must be reassigned to safe settings and those of female professionals experiencing various forms of violence. Prevention must take precedence, and the violence must stop.

FIQ is greatly concerned about the rate of violence in all forms in the health system. We very much hope that union-management cooperation can finally be established in our institutions so we can address this constantly rising scourge.

I would like to bring to your attention the fact that we just received the report of Quebec's auditor general today, many of findings of which are consistent with those of our federation. They include the fact that Quebec lags significantly behind other administrations and that there are persistent inequities among prevention workers.

Thank you for listening.

● (1625)

[*English*]

The Chair: Thank you very much for all your presentations.

Now we'll go to our questioning.

We'll start our seven-minute round with Mr. Ayoub.

[*Translation*]

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Thank you, Mr. Chair.

Thanks to the witnesses for being with us.

I find your testimony quite disturbing. There aren't a lot of positive aspects to the situation.

I had some questions in my mind as I was preparing. For example, for how long has there been violence in the health sector? Has it been increasing in the past 5, 10 or 15 years or it is a phenomenon that has always been there and never really been monitored?

Ms. Lapointe and Mr. Hayes, you've had different experiences. Do you have answers to that question?

[*English*]

Mr. Hayes, you can answer in English.

Mr. Thomas Hayes: Thank you.

There are two things of relevance for us in terms of thinking about the prevalence of violence in health care. The first is that it feels like it's been on the rise in the last few years, but we really think that's just because people are reporting it more and that they had been in an environment where they were just accepting it as part of their work.

To be honest, one aspect we talk about in my organization is that if you're attracted to health care as a vocation, as an employee— it doesn't matter whether you're a nurse or a clerk or a housekeeper— you're probably there because you care about other people. You put yourself out there for other people. You might be the type of person who just accepts that this is going to happen to you sometimes. I really honestly think that's true. That's something we talk about, and this is why there's been so much focus on increasing the reporting. We certainly have seen a great increase in reporting.

Mr. Ramez Ayoub: Thank you, Mr. Hayes.

[*Translation*]

Ms. Lapointe, what's your view on the increase in violence? Do you feel that violence has been rising in recent years, or was it always latent and not talked about?

Mr. Hayes mentioned that there might be more reporting, whereas I heard other testimony to the contrary. There are different views.

Ms. Linda Lapointe: Are you speaking to me?

Mr. Ramez Ayoub: Yes, Ms. Lapointe, I'm speaking to you. I come from Quebec, and I'd like to see what's happening in Quebec. So I'm speaking to you.

Ms. Linda Lapointe: Yes, we're convinced that there has been violence in the health care sector for a number of years. We're certain there has been a surge in violence of all kinds, those that were named earlier.

I'll speak mainly about the province of Quebec. Organizational violence has been rising in recent years as a result of the reforms, but it's also related to patients, who represent increasingly serious quality-of-care cases. Care is more complex because the population is aging, and we have a lot of mental health problems too. At the same time, we've also had enormous cuts to the health system in recent years, and those cuts have resulted in personnel reductions. Care professionals are at times left to their own devices during meal times and night shifts. Sometimes one nurse or nursing assistant works the night shift caring for 150 or 160 long-term care patients.

We try to be proactive and, at times, to reduce the use of medication so patients can recover their cognitive faculties to a greater degree, but that means professionals must be there with the patients to actually provide that care.

● (1630)

Mr. Ramez Ayoub: I understand.

I want to address another point that I also find troubling, and that's the gender of the managers. There are more men and fewer women in management, whereas there are more women and fewer men on the ground.

In citing those statistics, are you saying that the fact that there are more male managers, and thus more men responsible for administrative decision-making, leads to more violence and that there would be less violence if there were more women managers? I want to make sure I understand what you said.

Ms. Linda Lapointe: I'm not claiming that, but we wanted to draw a comparison. As I told you, the large majority of care professionals, 90%, are women. We wonder why there wouldn't be more women managers. We're simply saying that, since women are most affected by violence in all its forms, we think there would be greater sensitivity if there were more women managers and unit heads.

Earlier we cited other examples of violent situations that sometimes involve doctors. Health care is a highly structured and hierarchical sector. Harassment sometimes occurs, whether it be sexual, in the form of threats or expressed in a tone of voice. I'm not necessarily saying it's doctors engaging in it. Sometimes it's colleagues dealing with a heavy workload and constant pressure to perform. We think that, if more managers were women, there would be greater sensitivity to this violence and more measures would be taken to correct the situation. That's at least what we hope.

Mr. Ramez Ayoub: Thank you for your answer.

Another question I would like to ask concerns the health and safety committees. In the public domain, these are something that we know and that are widespread. We don't need to promote them too much. They exist and they're well established.

Aren't they part of health services in Quebec?

Ms. Linda Lapointe: Theoretically, they appear in our respective collective agreements, but they aren't taken seriously by the organizations or employers.

We do have a joint committee consisting of people from the union and management parties. However, when it comes to creating prevention programs and making them a priority, unfortunately not a lot of people care about them, although professional injury and disability rates haven't stopped rising.

Mr. Ramez Ayoub: What would have to be done for you to be heard by that kind of committee?

Ms. Linda Lapointe: For a long time now, FIQ, as a union party, has regularly conducted occupational health and safety campaigns. A week is set aside in October to promote preventive measures.

As I told you at the end of my presentation, the report of Quebec's auditor general contains particularly harsh findings and criticism of various structures, including the Commission des normes, de l'équité, de la santé et de la sécurité du travail. We haven't analyzed the report since we just received it today. We'll examine it over the next few days. However, significant work has to be done. It contains a whole chapter on how Quebec has been slow to act on prevention and occupational health and safety.

Mr. Ramez Ayoub: Thank you.

[*English*]

The Chair: Okay, we will now go to Ms. Gladu.

Ms. Marilyn Gladu: Thank you, Chair, and thank you, witnesses.

I come from a petrochemical background where we were very concerned about safety and security in the workplace. We would have incident reporting whenever there was an incident, and from that we would figure out the predominant causes and put mitigations in place.

From all the testimony we're hearing, it looks like data on who is perpetrating the violence is not available in many cases. We know anecdotally that it's people with dementia or mental health issues, people with addiction issues, and people who are frustrated with wait times and an inadequate staff-to-patient ratio. Are there other causes that you see a lot that I should add to that list?

Mr. Hayes, I figured you would have some data.

● (1635)

Mr. Thomas Hayes: Sure. I think that's a really important point. This is something that we've tried to focus a lot of attention on. You heard me say that we had 58 injuries in the last year. To add to that, we had another 530 incident reports that were reported just as a "good catch", meaning there was no injury, no first aid needed whatsoever, but just that this happened so that we could have some more data. As you said, we looked at what the contributing causes were.

From that we see in our experience that, yes, there are areas of the hospital that are higher risk and perhaps there are some patients who are more likely to be involved in violence. But really, at the first point, it can be anybody who has had a bad day and gotten some bad news, because this is what happens in health care.

Perhaps you're a parent whose child is being taken out of your custody and into child services. This is a really difficult life transition. We haven't talked about this much, but 70% of the staff in my environment are women. You've heard that from several of the other witnesses. We know that women are more likely to be the target of domestic abuse. What that means for us is that we know that at any given time, with 14,000 staff, there are probably hundreds of people who work for us who are living a very complicated life. Sometimes that domestic abuse can work its way into the workplace, or one of those people can have the right circumstances and the courage to ask for support. How can we provide a better, safer environment for them at the workplace?

Those are two kinds of spots. There are many others, but those are two that stick out to me that people don't think about a lot of times.

Ms. Marilyn Gladu: Those are great.

Dr. Gill.

Dr. Kulvinder Gill: The demographic of physicians here in Canada is changing dramatically. We now have more female than male medical students. In the coming decade we will have more female than male practising physicians, but there's also a changing demographic in terms of race.

In urban centres such as Vancouver and Toronto, by 2031 it is projected that the majority of the practising doctors will actually be people of colour. Research has shown that women are subjected to greater sexual harassment compared with men, and women of colour, in particular, are at an even greater risk.

To address the previous question about whether we are seeing an increase in violence or just more reporting of it, there's actually a combination of both. There's more dialogue, allowing for discussions to happen that previously were not happening. We are also seeing increased violence due to the demographic change, but also due to the increased strains on the overall health care system.

Ms. Marilyn Gladu: Excellent.

Let's talk a little bit about the issue of the very many women who are working in health care. Going back to my own history, I used to travel around the world by myself, which can be a dangerous thing in different parts of the world. Different strategies can be put in place to try to protect people. It's definitely not good to have people working alone, but we see this happening with the current resourcing.

We've had some helpful suggestions. One suggestion is for a buddy system. It can be especially effective for new people to be paired up with someone so they're never alone. That gives them a sense of security—and I recognize that there's a bit of a resource thing here. Other ideas are video surveillance, controlled entry, and warning signs on the wall like they have at airports, where you can't be violent or abusive with the workers or you won't be allowed on the plane. That was recommended for everywhere except those in emergency, where people do not want to refuse care to individuals even if they're violent. We also heard about incident reporting and follow-up training on de-escalation, and about resources to reduce wait times.

Are there other solutions we should add to that list?

Ms. Isabelle St-Pierre (Registered Nurse, Canadian Nurses Association): If I may add, the suggestions you're making are good when it's physical violence, and maybe physical violence from patients or their families, but there are also all the issues of professional-to-professional violence sometimes. When we talk about this type of violence, unfortunately, having a camera or a buzzer will not address that.

Again, it talks to the complexity of what's needed. Different types of violence will require different types of strategies.

● (1640)

Dr. Kulvinder Gill: The majority of [*Technical difficulty—Editor*] physicians actually practise outside of hospital settings. They're in the community and in private practices, often solo practices, so it makes it much more challenging to ensure their safety, particularly if it's a solo practice run by a female physician.

Mr. Thomas Hayes: Can I add to that as well?

Ms. Marilyn Gladu: Sure.

Mr. Thomas Hayes: Perhaps this was said and I didn't hear it, but I would mention two things. The first is a means of summoning assistance, particularly if you're alone, by which I mean something digital or a radio or a panic button, something that will go to a security office or a supervisor or someone else.

The second one that I think is really important and that we don't talk about much is a way to communicate the risk of violence, or perhaps a previous history of violence, by this individual. Most importantly, how do we communicate that between different health care providers? I introduced the Ottawa Hospital and its 19 sites, but there are other hospitals in the city. There are lots of long-term care providers. People come in from the police and paramedics. Let's say a patient is going from one care provider to another, to the physician or nurse or whoever. How do we ensure that as part of that handover, they will see that, “Oh, this is Mr. Hayes, and he might try to bite you when you try to feed him”?

The Chair: With that thought, we'll go on to Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you.

Thank you to all the witnesses for being here.

Isabelle, I think you mentioned that we need to have more standardized language. That was one of your suggestions. Can you give me an example of standardized language that would be helpful in addressing this issue?

Ms. Isabelle St-Pierre: “Workplace violence” could be an umbrella term to describe what happens in the workplace, but when we talk about “harassment” or “bullying” or “mobbing”, people interpret them in different ways. When you try to compare data between institutions, that's where the problem lies.

Let's say that for the term “harassment” the definition should include that it's repeated behaviour. If it's a one-time deal, then it wouldn't be called harassment. Maybe if we had some little terms that would discriminate between these, we would know what is meant by all the terminology. I see violence as being on a continuum, and there's escalation; for some people, incivility is considered violent, and for others it's not. That's where things get murky.

Mr. Don Davies: Perhaps if there were national guidelines or standards that all health facilities could implement, we would be able to get more standardized data.

That leads me to a question for you, Dr. Gill, and maybe for Isabelle as well. Can you give me a rough idea of what percentage of sexual harassment or assault is by co-workers, both horizontally and laterally, versus by patients and the general public?

Dr. Kulvinder Gill: Concerned Ontario Doctors is presently undertaking a survey of all of Ontario's practising physicians and medical trainees. We'll have more information, hopefully, by the end of the month. It addresses sexual harassment and violence, along with many other things.

A survey of Canadian medical residents just came out a few months ago. According to the survey, most of the violence and harassment comes from patients, followed by senior attendings, followed by peers.

Mr. Don Davies: Isabelle, do you have any evidence on that?

Ms. Isabelle St-Pierre: There was a 2005 study done that was financed by Health Canada and Statistics Canada. It was pan-Canadian, and it showed, again, it was mostly patients and their families, followed by health care professionals. I can give you the statistics if you want.

Mr. Don Davies: I asked this question to our last panel earlier this week, and they didn't know the answer. I'm wondering if you have any evidence.

We know that workplace violence is happening in both a culpable and non-culpable way. We have examples of the 85-year-old suffering from dementia or the person who suffers from psychosis or bipolar disorder all the way to someone who really should know better, like patients or people who are simply angry and unable to control themselves.

Can you give the committee a broad idea of what percentage of this violence happens among the culpable versus the non-culpable? I think that radically different perspectives and responses have to be developed for each of those two categories. Can you give us an idea of how that breaks down?

● (1645)

Mr. Thomas Hayes: Sure. I'm just pulling up the number of flags that we've applied. Within Ontario hospitals, you're required to keep track of this information so that you can communicate the risk back and forth. At the Ottawa Hospital, we track whether violence has been prevalent between family members or patients themselves. That gives us some sense as to whether it's culpable or non-culpable, assuming that a family member or visitor is more likely to be culpable versus the patients themselves, who are more likely experiencing delirium or dementia.

These numbers are startling, but we've been tracking this information since 2010. Currently among our patient population, we have just over 3,500 active violence prevalence flags. Just over 3,000 of those relate to patients, and several hundred relate to family members or visitors.

Mr. Don Davies: I will stay with you, Mr. Hayes.

In our last meeting, Linda Silas, President of the Canadian Federation of Nurses Unions, cited the Ottawa Hospital as an example of a health care facility that had implemented best practices around violence prevention, and she recommended that it was something this committee should look to as a model.

What are those best practices? What are you doing that has been so positive?

Mr. Thomas Hayes: Thank you, and I thank Ms. Silas for that compliment as well.

We've been working hard on this issue. The key thing for us has been, first of all, collaboration. There is collaboration with front-line staff across the board, whether it's a physician, a nurse, a clerk or a housekeeper. There is collaboration with the joint health and safety committee. You've heard from other witnesses that this is in place, but sometimes it's not effective. In our organization, we changed that by having executives as members of the joint health and safety committee so that there is much more serious attention paid to that committee.

Then there is collaboration with labour groups. Maybe we thought we had all the answers before. You tend to think of it that way if you're in a management role. I hate to say it, but that can happen. You fall into habits like that, and sometimes you need to stop and think about front-line staff. Engaging with an organization like the ONA—the Ontario Nurses' Association—and other nursing labour units helped us to get back to the evidence around best practices.

Then lastly, in Ontario there is the Public Services Health and Safety Association, one of the safety associations under the Ministry of Labour, and it has published evidence-based best practices that are available on their website. We have taken a look at those, along with other recommendations from other provinces.

Mr. Don Davies: How are we doing for time, Mr. Chair?

The Chair: You have 19 seconds.

Mr. Don Davies: Bill C-434, which I introduced in the House a week or two ago, would make violence against a health care professional in a health care setting an aggravating factor in sentencing.

I'm just wondering if you could give our committee some sense of how your members and the people you represent would take that. If that were legislated into law, what would be the response?

Dr. Kulvinder Gill: That's actually one of our key recommendations. The Australian government of several years ago passed similar legislation, and it is applicable to front-line physicians, nurses and paramedics. A patient who is engaged in serious assault can be sentenced to up to 14 years.

Presently, there is zero accountability from patients. In terms of your previous question about dementia versus patients who are actually cognizant of their behaviour, I think a lot of that has to do with the type of health care facility.

In emergency room settings, for example, we tend to see more patients who are suffering from other illnesses that would impair their ability. We see more addiction and mental health issues there. In family doctors' clinics and in specialists' clinics, we see patients who are very alert and very aware of their actions. There's a significant difference in terms of patient culpability based upon where the care is provided.

● (1650)

Mr. Don Davies: Thank you.

The Chair: Thanks very much.

Now we'll go to Dr. Eyolfson for seven minutes.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you, Mr. Chair.

Thank you all for coming.

I'll start with you, Dr. Gill. We have something in common. I'm an emergency physician. I worked in emergency departments in Winnipeg for 20 years. Much of what you were describing about the challenges of emergency departments resonated a lot with me. We find that when they cut front-line services, people come to the emergency department to fill the gaps. When they cut in-hospital services and you can't admit them, they basically can't go anywhere. I've always called the emergency department the only place that can never say no.

We often find directives, particularly from administration, to increase the flow. They'll have all sorts of spreadsheets to show the flow isn't the way it should be, but then we're told not to make excuses when we tell them we don't have the resources to increase the flow.

What would you tell administration of hospitals about this? Do you think this attitude of leaving it for the emergency department to figure out is making the problem worse?

Dr. Kulvinder Gill: I've had the experience of working in many different provinces. I'm actually originally from Manitoba and I did my medical school training out in Winnipeg, so I'm very familiar with the hospitals there as well.

Regarding flow, I think it's very important for administrators to understand that patient care requires time. Quality assessments and plans require time. We have burnout rates here in Ontario of 63%. I cannot stress enough how much of a serious public health care crisis this is. We have been advocating for this for three years, but no level of government has taken us seriously.

Physicians have the highest rate of suicide compared to any profession. The mandatory reporting is cruel. It's cruel and it needs to change. There is no reason that in every other profession, mental health and physical health are considered to be equal, except for physicians.

Regulatory bodies need to adapt and change. Again, the Australian model is an amazing model to follow. In 2017, their governments passed legislation to support physicians who were suffering from mental illness instead of punishing them. Their governments have taken this issue very seriously. They have even created a front-line ombudsman, which is one of the other recommendations that we had. That allows front-line doctors, nurses and health care workers to actually bring their concerns to an independent body that can then address them. It also allows for confidential reporting of the actual incidents.

Those are part of our key recommendations. We would strongly urge the committee to look into many of the models that currently exist in Sweden and Australia. They are decades ahead of Canada in terms of addressing these issues.

Mr. Doug Eyolfson: That also resonates a lot with me.

I was hoping things would have changed since the nineties, when I was in residency at the University of Manitoba medical school. In our residency programs, across the various programs, we had three residents die by suicide in a 15-month period, and not a lot changed. I actually discovered the body of a resident who had committed suicide and I was not offered any mental health services. Actually, no one thought it was unusual that I showed up for work the next day. It didn't occur to anyone to tell me, “Maybe a couple days off would be really good for you.”

I didn't see any changes over the next few years and I was hoping that in the intervening 20 years we would see more changes.

Dr. Kulvinder Gill: We've actually seen the opposite happen.

Sadly, in 2017 the Ontario government passed legislation giving the regulatory college access to physicians' private medical records.

Mr. Doug Eyolfson: Wow.

● (1655)

Dr. Kulvinder Gill: Not only is it now mandatory to disclose mental health issues, but the regulatory college in Ontario also has access to physicians' private personal health records. This has created even further barriers to physicians' access to care.

These are serious issues. For some reason, the Ontario government does not see physicians as human and has completely dehumanized the profession. We need to start thinking of doctors as being human and to start treating them as we would treat patients.

There are significant issues within the Ontario regulatory college. Just yesterday we became the first jurisdiction in the entire world to lose our freedom of conscience. No such legislation exists anywhere else in Canada and no such legislation exists anywhere else in the world.

We have also lost our freedom of due process through the regulatory college and our presumption of innocence, which also came with the passage of Bill 87 in 2017.

There are significant issues and challenges for front-line doctors, not only in terms of trying to deliver front-line patient care with limited resources and with an increased escalation of violence and sexual harassment on the front lines, but also in terms of roadblocks and barriers being put up by the regulatory college and by the government that actually impede access to essential mental health and physical health care, which is crucially needed.

Mr. Doug Eyolfson: Thank you. I did not know about the mandatory reporting of mental health. That is, quite frankly, horrendous.

I don't know if Manitoba's doing that. It's something I will look into.

Dr. Kulvinder Gill: It is.

Mr. Doug Eyolfson: You're saying it is. That is actually quite horrendous, but I'm glad I know that now. I think this situation needs to be looked into.

In the last 30 seconds, one of my frustrations in the emergency department was that because so many services are cut outside, there are a lot of initiatives that people bring to the department, saying that the emergency department is perfectly positioned to do this. They're not emergency things, but no one feels good saying no. For example, it's “Let's offer flu shots to everyone who comes in, because we can catch them here”, or other things, such as “Let's offer smoking cessation programs to any smoker who comes in.” These additional things make us busier.

Is it time for the emergency medicine community to start pushing back and saying, “We're already overloaded in what we're doing. Don't make us do more things that aren't in our mandate”?

Dr. Kulvinder Gill: We certainly don't have emergency rooms in Ontario giving flu shots. There are now more and more urgent care facilities that are being positioned close to emergency rooms. Oftentimes the triage nurse has the ability to redirect patients away from the emergency room to the urgent care facility, which is sometimes attached to or neighbouring the ER department. That allows for appropriate care to be delivered in an appropriate setting.

Mr. Doug Eyolfson: Thank you very much.

The Chair: Thank you very much.

That completes our seven-minute round. Now we go to a five-minute round, and we start with Ms. Gladu.

Ms. Marilyn Gladu: Thank you, Chair.

I'm going to start with Thomas Hayes. You are heralded as being the “best practice” guy. What is your annual budget for your department?

Mr. Thomas Hayes: First of all, my department is complicated, because it includes safety, security, parking and staff health. I'll set the parking aside and just talk about safety, security and staff health. If I look at that, I would say our annual budget for those groups is in the range of about $2 million. Part of that would include the budgets we have for the training of staff across the hospital—that falls under my purview as well—as well as budgets for supporting people in their return to work.

If I were to put that in a more concrete type of format, I would say I have a staff of roughly 60 protection agents who are members of the Ottawa Hospital. We also have about another 60 security guards who are contracted out so that we can raise or lower our staffing complement. I have a safety and staff health team of about 35 people, which includes safety officers, nurses, physiotherapists and other health individuals who are involved in either taking proactive work supporting joint health and safety committees or supporting staff in whatever their health needs are.

● (1700)

Ms. Marilyn Gladu: They service the 19 locations that you have.

Mr. Thomas Hayes: Correct.

Ms. Marilyn Gladu: Very good.

I also want to talk about whether there's acceptable treatment in terms of mental health assistance or PTSD coverage once violence has occurred. What exists for nurses, doctors and health care providers?

Anybody can answer.

I'll start with Josette.

Ms. Josette Roussel: In the hospital sector, there's WSIB. There's a workers compensation board. Depending on the injury, there's a reporting mechanism, and if you need medical assistance, there's time off. You're covered under that type of insurance in hospitals.

In other sectors, depending which group you're part of, there are some insurance services, but I'm not sure exactly what they are. There are some differences in jurisdictions. Having been a nurse in Ontario, I'm just speaking now of Ontario.

Ms. Marilyn Gladu: Dr. Gill, would you comment?

Dr. Kulvinder Gill: The majority of Ontario's front-line physicians are actually in a private practice and have no benefits. If they do take time off work, not only are they still covering the overhead for their staff but they are also still covering the overhead for their clinic. Once they do come back, all the patients they had cancelled need to be rescheduled. Oftentimes, physicians have an increased burden once they return to work.

We also previously had OPIP, the OMA priority insurance program, which was very minimal coverage through the Ontario government. However, due to escalating cuts, the Ontario government has not only cut mental health coverage, but now it's only a few hundred dollars a year for each physician. There are new graduates coming into the program every single year, but the government hasn't increased funding accordingly, so there's a smaller pool being split among a greater number of people.

[*Translation*]

Ms. Marilyn Gladu: Now I'll turn to the Fédération interprofessionnelle de la santé du Québec.

Are there enough services in Quebec for people who've experienced violence?

Ms. Linda Lapointe: There's a good service for that. Support is offered and all female health care professionals have group insurance that enables them to access it. However, they have to go get the psychological support they need themselves.

One of the federation's pet issues is the ratio projects designed to reduce the number of patients per nurse, per nursing assistant and per respiratory therapist to prevent these forms of violence. You'll be hearing about this in the next few years.

Generally speaking, there is good support, except that all this prevention unfortunately isn't a priority for the organizations. There is really a lot of work to do on the outreach plan before we can say enough is enough.

We have policies on violence, harassment and discourteous behaviour. All health facilities have one, but it's nevertheless a burdensome process. We claim that underreporting is really a problem precisely because of the burdensome reporting process. There's a mediation process for verbal violence and discourteous behaviour between colleagues, but it's quite complicated. Since people feel it won't help in any case, they don't engage in the process.

Ms. Marilyn Gladu: Thank you.

[*English*]

The Chair: Okay. Thanks very much.

Now we'll go to Mr. McKinnon.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): Thank you, Chair.

My first question will be to Ms. St-Pierre.

Most of our discussion on violence has involved relationships with patients and people associated with patients, but you indicated that there's also professional violence. I would suspect that means, basically, violence among co-workers.

If we take out of the equation all of the patient-related violence, is the health care environment more dangerous than, say, other working areas in terms of violence among co-workers?

Ms. Isabelle St-Pierre: I would say that it is. We are seeing an increase everywhere. Part of it is workloads, with the work environment being so stressful and people not being able to help one another or not having time to get to know each other. Attributing ill intent.... Sometimes violence is subjective. You maybe perceive that someone is mean to you when in fact it was something else. Perhaps they were rude, but there wasn't an intent to hurt you.

I think it's complicated. We know that this form of violence, when it's worker to worker, is usually more damaging to the staff. You expect your colleague to have your back. If you have that day after day after day, that's then you go on sick leave and get depressed, and it affects your self-esteem.

● (1705)

Mr. Ron McKinnon: In the health care environment, people tend to be substantially overworked and overloaded in many ways. I believe you're saying that this burden overwhelms the regular sort of workplace or occupational safety rules that apply for everybody.

Ms. Isabelle St-Pierre: I agree with you. It also goes further than that. For example, if I go for a break, someone will look at me and say, “Oh, you have time for a break? You must not be that busy.” It gets to be that when you take your lunch or break or go to the bathroom, it's almost frowned upon by your colleagues. There are cliques like that and situations like that.

Mr. Ron McKinnon: Thank you.

Dr. Gill, you said that the majority of physicians in Ontario—and by extension, I would suspect, across the country—are in private practice. I would think that this means most physicians are better able to control their environment in terms of the working conditions they provide to their staff and so forth.

What can physicians in private practice do to improve the safety of themselves and their staff?

Dr. Kulvinder Gill: Over the past several years, physicians in private practice have been trying to ensure the safety of their secretarial staff. They're often the very first people who encounter a violent patient at the time of check-in, for example. Physicians are creating more barriers between the secretarial staff and patients.

Aside from that—as I had mentioned earlier—if the de-escalation attempts fail, often the only avenue that front-line physicians and the secretarial staff have is to call police. That's often after an assault or after the violence has already escalated.

Mr. Ron McKinnon: Would the availability of things like panic buttons, as Mr. Hayes has indicated, be a useful tool for such workers?

Dr. Kulvinder Gill: What does a panic button trigger? That would be the question. Would it be triggering the local police department? If that's the case, I know that where I practise, the Peel police are extremely overwhelmed. Despite the increased budgeting, they're still struggling to deal with the sheer volume of calls that they have. By the time the call is attended to, often the event has already transpired.

It's a very challenging situation. Aside from putting up signs, creating barriers, installing cameras, etc., there's very little that front-line physicians within the community have available to them in terms of addressing the violence. With legislation such as MP Davies has brought forward, patients would know that there are serious consequences for their actions, and it would help to create a significant deterrence to that type of behaviour.

Mr. Ron McKinnon: Thank you.

The Chair: Thanks very much.

Now we go back to Ms. Gladu.

Ms. Marilyn Gladu: Thank you, Chair.

I want to talk a little bit about resourcing and trying to reduce the wait times to get at that part of the frustration.

There's a shortage of doctors and nurses across the country. The most extreme situation I've seen is in Cape Breton, where they're missing 52 emergency room physicians and a vascular surgeon. If you cut an artery, you will either lose a limb or die because they can't get you to Halifax in time. Across the country we're seeing nursing shortages.

I have two questions. The first one is this: What is the correct ratio of nurses to patients that we should be trying to put into place for the various levels of service, knowing that the ICU is different from emergency, etc.? Do you have any ideas on that one?

● (1710)

Ms. Josette Roussel: What we are using is based more on the needs of the patients, rather than going directly to the ratio. It means looking at the needs of the patients.

I know seniors' care is rising, and we've done a recent report on that. We need to plan for more resources by looking at different models and different categories of nurses. We have to do things differently. We can no longer use the same models that we have. We know things are not getting better and we have to use different services in the community so that individuals will not go to the emergency and will not bottleneck emergency services, so that those services that are needed are used for the patients who need them.

Seniors' care is an area where we're thinking of the population's needs and how to provide the resources they need. Also, rural and remote health care, as you suggested, is an area where we are concentrating our efforts and looking at ways to recruit nurses to move to those areas, as well as looking at ways to provide services in those areas using technology and using different models to enable nurses to work to full capacity. There are problems with some jurisdictional regulations and policies that create barriers.

Those are all solutions that are multipronged. It means having a global sense of the situation and of the needs of the population right now.

Ms. Marilyn Gladu: I see that across the country that day cares have one worker for every eight children. We know that in Alberta's nursing standards for long-term care facilities, for example, it's one nurse for seven patients. We know that in Ontario, the standard for ICUs is three patients to each nurse, but as you said, it can depend on the condition of the patient.

In terms of doctors, did I hear you correctly, Dr. Gill, that one million people in Ontario don't have a family doctor?

Dr. Kulvinder Gill: It's now over one million.

Ms. Marilyn Gladu: I'm not surprised at all. In Ottawa, the average wait time for a family doctor is six years, so this is a huge issue.

Dr. Kulvinder Gill: The wait times for some specialists have actually ballooned to even beyond three years now, so it's extremely dramatic. Canada has one of the lowest doctors per capita rates among OECD countries. Rather than trying to recruit and rather than trying to train more physicians, we've done the opposite.

In Ontario the government cut 50 residency positions, and over the last three years we've actually trained 150 fewer physicians. The toxic climate created by the regulatory body, along with the escalating cuts, has actually driven physicians away from the the province.

Not only are new grads not staying in Ontario, but doctors closer to the end of their careers are actually retiring earlier. We're seeing more and more physicians starting to work outside of OHIP, simply because it's become so toxic through the CPSO and the Ontario government that doctors are now actually leaving the profession of medicine.

Ms. Marilyn Gladu: We see different situations across the country, but anecdotally I'm hearing that there are enough Canadian people trained as doctors that we could put a lot more doctors into the system. There are a lot of Canadian-trained doctors who are not actually able to successfully get a match or get a placement.

In B.C. specifically, they have an issue because of the financial incentives they've put in place provincially: It makes more sense to be an ER doctor than it does to be a family physician, because you have no overhead as an ER doctor for basically the same salary.

Are there a number of solutions that you would recommend in order to address the doctor shortage?

Dr. Kulvinder Gill: As I said, the government really needs to start to see physicians as humans. If there's one message I can bring to this committee, it's that doctors are humans. Start treating doctors as humans, and that means taking away a lot of these toxic policies that exist. There is no reason physicians should not have a fair due process. There is no reason physicians should not have the presumption of innocence. There is no reason physicians should not have protection for the freedom of conscience. There is no reason physicians should not have protection of free speech. There is no reason that physicians should not be treated like every other Canadian citizen.

Right now in Ontario, physicians are literally second-class citizens. Let that sink in. Physicians are second-class citizens in Ontario. The very people who are dealing with life-and-death situations, who have spent over 10 and for some nearly 20 years of formal education to be able to provide you with the care that you need at your most vulnerable time, are being treated as though they are subhuman. We have a serious problem.

If we don't start treating front-line physicians as humans, we are going to have a serious problem, because there will be no front-line physicians left, especially after the appalling Ontario court ruling that happened yesterday. It's unprecedented anywhere in the world for freedom of conscience of physicians to be removed. Doctors no longer have freedom of thought. Once that happens, there is a serious problem.

The court made it seem as though there was a dichotomy in terms of trying to pit physicians' rights against patients' rights, but that was a false dichotomy. Every other jurisdiction in Canada figured it out. Every other jurisdiction in the entire world figured it out, so clearly solutions exist. When governments become hostile towards front-line doctors, they leave the profession.

● (1715)

The Chair: Okay. Thanks very much.

Now we go to Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair. Thank you all for being here.

Dr. Gill, I represent Brampton South. Thank you for serving Bramptonians. I know we have approximately 900,000 residents but just one hospital.

We heard last week about crowded hospitals, lack of physicians, and cyber- bullying. You also mentioned that. Can you explain to me how we can prevent physicians or health care professionals from cyber-bullying?

Dr. Kulvinder Gill: That's extremely challenging, especially because the Internet affords individuals with anonymity. When someone can remain anonymous, there's no accountability for their actions.

There is also something known as RateMDs, which has become a very toxic environment. It's actually owned by the Toronto Star corporation. They even write negative reports and then solicit physicians to have those negative reports.... According to one National Post article, those reports are possibly even being written by the very company itself. Things like this are extremely toxic. Not only are physicians then dealing with toxicity on the front lines—a toxic college, a toxic government—but it's now a toxic Internet as well.

I think that's where government can come in and play a positive role. When businesses are profiting off of the misfortunes of others by creating false reviews and then trying to target physicians to subscribe, at an enormous amount monthly to have those reviews removed, we have a serious issue.

One successful libel suit came forward here in Ontario just this past week against RateMDs. Hopefully there will be more, so that the toxicity ends.

Ms. Sonia Sidhu: Cybersecurity is one main priority for our government. If you have any solutions, you can email us.

If any of you has a suggestion on how the federal government can address that issue, please send it to us or email it to us, and we will look into it.

How can we defuse the situation of training for health care professionals? Can you talk about that?

Dr. Kulvinder Gill: Medical students start experiencing sexism and racism from patients—for example, sexual harassment—when they are in their early clerkship years, even before they have gone into their formal residency training.

From the time I trained to even now, there has been no formal training in how to deal with a patient who becomes violent or uses racial slurs.

There was an event in Mississauga about two years ago that made national and international headlines. A patient went into a walk-in clinic and was demanding to be seen by a white physician, and a lot of derogatory language was being used. At that time, the health minister and the premier were denouncing it. The college had indicated that physicians are afforded protection under the Ontario Human Rights Code, but also indicated that the college has absolutely no policy to actually deal with it.

That was one of our 11 recommendations: not only having mandatory training during medical school and in the residency training curricula, but also ensuring that provincial and territorial regulatory bodies develop policies to ensure that basic human rights codes are actually protected and there are policies to deal with harassment issues.

● (1720)

Ms. Sonia Sidhu: Thank you.

The Chair: Thank you very much.

Now we go to our very last question, with Mr. Davies.

Mr. Don Davies: Thank you.

I don't know if it was Josette or Isabelle, but one of you used the term “horizontal workplace violence”. I'm just wondering if you could tell us what that means.

Ms. Isabelle St-Pierre: “Horizontal” is basically same-level staff, so nurse to nurse, let's say, or physician to physician. “Vertical” would usually be hierarchical, such as a boss to an employee.

Mr. Don Davies: Okay. Thank you.

Madame Lapointe, if I understood correctly, you said that Quebec was behind the rest of the country in terms of dealing with workplace violence. If I understood that correctly, could you tell us *pourquoi*?

[*Translation*]

Ms. Linda Lapointe: What I said comes from a report by Quebec's auditor general that was tabled in the National Assembly. Since we just saw it today, we haven't managed to examine it.

That report provides findings on occupational health and safety. It's the auditor general himself who says we're lagging far behind other organizations. The auditor general makes 11 recommendations and several findings, but we unfortunately didn't receive the report until this afternoon, and I haven't been able to read it. However, it contains an entire chapter on the subject.

Mr. Don Davies: Thank you.

[*English*]

It seems there are multiple factors that go into this, of course. One of them is understaffing.

Another one that was mentioned was this persistent culture among health care professionals, the expectation that workplace violence in health care is somehow expected and professionals just have to suck it up.

I'm wondering how prevalent that attitude is among your colleagues, and whether you have any suggestions about how we can change that culture.

Ms. Isabelle St-Pierre: It is very prevalent. I would say that every person knows that at some point they will be treated badly, whether it's physically, such as being scratched or spat on, or through name-calling. It's very prevalent.

It is not reported, exactly because if we were to report every incident, that's all we'd be doing, and nothing comes out of it, so that's—

Mr. Don Davies: It has been normalized.

Ms. Isabelle St-Pierre: Yes, totally.

Dr. Kulvinder Gill: It's also ingrained in institutions, especially when it's coming from someone in a position of authority or power within the institution.

Rather than actually addressing the problem, often the institution will do everything to protect the institution, and physicians, nurses and health care workers are then often driven out of the organization.

Mr. Don Davies: Thank you.

The Chair: Our time's up.

I want to thank the panellists on behalf of the committee for bringing this almost personal information to us. We really appreciate it, and it will help us write a report that hopefully will help your situation, because we're certainly hearing about a serious problem that has to be addressed.

On behalf of the committee, thank you all very much.

Thank you to our friends in Quebec who were on video conference. It's not easy to do that. Thanks very much.

We're going to suspend the meeting for a minute, and then we have two small pieces of committee business.

[*Proceedings continue in camera*]