

HANSARD

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COMMITTEE

ON

HEALTH

Tuesday, December 8, 2020

Via Videoconference

Ongoing Work in Organ and Tissue Donation

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Gordon Hebb
Chief Legislative Counsel

WITNESS

Dr. Stephen Beed, Medical Director,
Nova Scotia Organ and Tissue Donation Program



House of Assembly
Nova Scotia

HALIFAX, TUESDAY, DECEMBER 8, 2020

STANDING COMMITTEE ON HEALTH

1:00 P.M.

CHAIR
Ben Jessome

VICE-CHAIR
Keith Irving

THE CHAIR: Order, please. Good afternoon, everybody. Thank you for your time and effort this afternoon.

My name is Ben Jessome. I'm the MLA for Hammonds Plains-Lucasville and I am the Chair of the Standing Committee on Health. This is our first virtual meeting. We went through the Community Services Committee meeting this morning relatively well. I expect more of the same. Thank you to our friends at Legislative Television and our clerk for helping us to make this possible.

Today we have Dr. Stephen Beed here to present to the committee on the ongoing work with respect to organ and tissue donation. Dr. Beed, thank you for being here today.

Just a couple of small housekeeping items. A reminder, as always, for folks to keep their phones on silent. They'll be close by today, so I'll ask everybody to mute them or put them on a setting that won't disrupt. Staff who are not members are going to have their screens turned off and their volume muted. I'd ask that all members and speakers when they are not speaking to hit their mute option while other people are speaking.

We're going to make an effort for folks not to leave the meeting. If necessary, leave your visual on to the best of your ability. At some point, if I need to confer with legislative staff, I may call for a brief recess. We'll play that by ear.

If anybody has any technical issues ongoing, I'd ask you to reach out to myself or Ms. Kavanagh. I think that I've hit everything.

I'll note that Dr. Beed had an additional item that he wishes to submit to the committee based on some statistics that might come up over the course of the meeting. That might not be in your hand right now but that will be soon to follow.

At this point, I think that I will begin with some introductions, starting with Mr. Horne, please.

[The committee members introduced themselves.]

THE CHAIR: We're also joined by Mr. Gordon Hebb and Ms. Judy Kavanagh, who will be supporting the efforts of today's meeting. Thank you, folks, for being here, as well.

Without further ado, I'll turn it over to Dr. Beed, who's in his scrubs, I can see, to give some opening remarks and then we'll open the floor to some Q&A. Please and thank you, Dr. Beed. Please proceed.

DR. STEPHEN BEED: First of all, thank you very much for the invitation to this committee. I appreciate the opportunity to discuss what I think is a pretty exciting project. I am coming from the hospital, where I'm covering the ICU, so you're wearing your business attire, and to some extent I'm wearing mine. I will ask your indulgence as I sit here in my pyjamas while you sit here wearing a tie.

I will take a few minutes with some opening remarks and then I look forward to having a conversation with you as we discuss this topic.

In terms of the formal remarks, I'd like to start first of all by introducing myself. I'm Stephen Beed. I am an adult intensive care physician at the Queen Elizabeth II Health Sciences Centre. For about 15 years, I've been the medical director of the Nova Scotia Organ and Tissue Donation Program here in Nova Scotia. I'm very pleased to have the chance to meet with the committee.

As you well know, the Human Organ and Tissue Donation Act, which comes into effect on January 18, 2021 will improve the health care for Nova Scotians by making it possible for more Nova Scotians to donate their organs and tissues at the time of their death.

Organ and tissue donation, I would be happy to argue, is much more important than many of us realize for the effect on the people and the family it directly affects and for our society. In Nova Scotia, at any given time, there are about 100 people waiting for an organ transplant so that they can live a healthier and more productive life, and for some of them, receiving this organ is literally a matter of life and death. People with end-stage organ failure suffer on a daily basis. They're living difficult lives while they await a transplant.

Some will become too sick to actually qualify for a transplant; others will die while awaiting that life-saving intervention.

It's important to note that almost all of these people who are on the wait-list have acquired disease rather than congenital disease. They at some point saw themselves as healthy until they got sick. We cannot know our future, so this could be the fate for any one of us as we sit here in apparent good health, and I would argue that if this is to be our fate, wouldn't we want to be supported by a system that increases the chance that an organ or tissue is available if we needed it?

It's important to note that - and this is Canadian data - it's about six times more likely in your lifetime that you will need an organ than it is that you would become a donor. As we sit here thinking about our futures, we can say that it is a lot more likely that you might find yourself in need of that life-saving organ, or certainly the people in your circle.

We also know that thousands of Nova Scotians are benefiting from tissue transplantation every year. A tissue donation from a single donor, who can donate bones, skin, heart valves, tendons, corneas - that can renew or save the life of up to 75 people. The patients that benefit - clearly burn patients, children with heart valve problems, the visually impaired, and many, many people with orthopedic and mobility problems - are examples of patients who can benefit from tissue donation and transplantation. Tissue donation can be life-saving, but it's always life-changing.

It's important to think about this in a broader lens. When families make the decision to donate, their neighbours directly benefit. Last year, there were 53 Nova Scotians who received organ transplants, and more than 1,000 received tissue. Donation is obviously affecting the recipients, but it's also affecting their families and their friends, their colleagues, and acquaintances who love and support them.

The benefit from their renewed life and improved health after transplant is obvious to a broad circle. This seems like the obvious reason for why I'm supporting this, but it's actually not what motivated me to support the development of this program. I help take care of critically ill patients in the intensive care unit, and the care of these patients obviously must include care for their families. Patients who become donors have almost always had a very sudden, catastrophic injury to their brain. The people who become donors have severe trauma like a car accident, bleeding from a stroke or an aneurysm, or lack of oxygen like after a heart attack if their heart would have stopped. In these circumstances, their families saw them as healthy just hours before we meet them in the ICU to discuss a devastating illness. These families are scared, they're overwhelmed, they're exhausted as the trajectory of their loved one's illness is defined, but sometimes there is no medical therapy that can change the injury and patients unfortunately will die.

The families dealing with this sudden loss are devastated, and the question, can anything positive come from the terrible tragedy is raised. Organ and tissue donation can have a powerful, positive effect on those families in the midst of dealing with their tragedy.

We shared with this committee a video of Kelly Patterson who lost her son, Steven, in a tragic car accident. The decision to donate Steven's organs helped Kelly through a very dark period in her life. This gift of life not only impacted the recipient, but fathers, husbands, wives, mothers, daughters, sons and countless others in that circle who were given a second chance because of the decision that was made.

Clinically, I see people of all ages and backgrounds who become recipients and donors. They donate organs, eyes, tissues. Lives are transformed and donor families can turn a terrible loss into some hope. The gift and the benefit their loved ones provide to other families can assist in their experience of grief, knowing the lives that they've saved. This may not lessen the pain of the grieving process, but it gives families some comfort knowing the last gift their loved one made was saving and changing the life of somebody else.

That's the reason I try to support donation. The anonymous recipient is not my patient, but the patient in front of me and their families deserve optimal end of life care and offering them the gift of donation is part of that.

I have never had a family become upset when we've approached them regarding donation, even when they choose not to consent, but I've had families contact me weeks after their loved one dies very upset when they realize that nobody asked them about donation and the loved one would very much have wanted to do that.

I'll never forget a conversation I had with a woman. She described her dad to me. In her words: My dad was always the guy helping out our neighbours, shovelling their driveway or helping with chores when he was alive. I know he would want to help people if he could when he died, but nobody asked us.

Until recently, donation education was not provided to physicians during medical school or residency or other members of our health care team like nurses or respiratory therapists. There is a whole generation of health care providers out there who just don't know that much about donation. We are changing that - our system is better now and we've addressed some of those issues.

It's important for Nova Scotians to understand that organ donation opportunities are actually quite rare, and so we cannot afford to miss a single one. In a given year in Nova Scotia, there are about 4,000 people that die in hospitals, but less than 80 of them will meet medical screening criteria for organ donation. Typically, about 20 go on to donate. If you think about that, if a single donor is missed, 5 per cent of our opportunity is gone and four to six people may have had a second chance at life lost. These are rare events that we need to focus on.

The new law, based on the premise of deemed consent means if you don't register a decision and have not told your family that you do not want to be a donor, then if a donation opportunity presents itself, you will be considered as if you've consented to donation after death.

[1:15 p.m.]

There are exceptions in the law: new residents of Nova Scotia, part-time residents such as students or temporary workers, people who do not have the capacity to make decisions, and those under 19. There are exceptions but for most of Nova Scotia, this law applies.

Our health care team will always speak to the donor family to confirm the donor's last-known wish if an opportunity for donation occurs. You can register your decision to be an organ and tissue donor, or your choice to not be a donor, opting out at any time.

One of the arguments that has been made against deemed consent, which is what this is called, is that an organ is no longer a gift or a donation in the true sense of the word. It may appear as if something was "taken" and that's just not true. We know many people feel strongly about wanting to give this gift. You can continue to urge individuals to make a donation decision, register it, and discuss that decision with their family. Someone who wants to give this gift can certainly make that clear as can individuals who do not want to donate.

The level of awareness and support for organ donation and tissue donation in Nova Scotia is very high. A recent research study from 2020 found 95 per cent of participants supported organ and tissue donation and they knew they could register to be an organ and tissue donor.

Nonetheless, we understand some individuals will not want to be a donor and we respect their right to make that decision and have developed a registry to record that. Interestingly, the number of Nova Scotians who have chosen to opt out is just over 1,300. A little bit over 1 per cent of the population, so it's very low. We expect that to increase a small amount as January approaches.

At the same time, we have an Intent to Donate registry in Nova Scotia. We have the highest registration rates in the country with about 54 per cent of the population indicating they have already registered their intent.

We made a commitment to educate the health care communities as well as the public at large with particular emphasis on historically marginalized communities. We work closely with our partners at the Department of Health and Wellness regarding this legislation. They've been leading a public awareness campaign that has included television, digital, and social media.

Our awareness work continues with engagement and meeting with stakeholder groups and government partners to aid us in communicating with hard-to-reach communities and those with specific needs and concerns. This work will continue as January 18th draws closer and will continue long afterwards as we strive to keep Nova Scotians informed.

The positive impacts of this Act go well beyond the legislative work. It will strengthen our work in the hospitals and communities across the province. Indeed, if the change was strictly legislative, it's unlikely we could expect a positive outcome, but this law has come with a commitment to support transformation of the donation and transplantation programs here in Nova Scotia.

That transformation includes investment in enhanced staff education, information technology, data system updates, policy and procedure renewals, and new hires for the organ, tissue, and transplant programs as well as support for communication and campaign planning. Although the COVID-19 pandemic has slowed the process in some cases, the support that accompanies this legislation allows for hiring people into dedicated clinical and support roles that will impact donation and transplantation in Nova Scotia.

In the donation program, the role of our coordinators has changed, and we've increased the number of coordinators as we accept the Premier's challenge to provide donation opportunities anywhere in the province. We have engaged four new donation physicians who will be based in the Annapolis Valley, Cape Breton, and in Halifax. We plan in the coming years to engage several more donation physicians, all of whom will work part-time along with their regular critical care duties.

We were able to secure, in conjunction with colleagues from Nova Scotia Health, the Department of Health and Wellness, and other groups nationally, a grant for \$1.1 million from Health Canada for a three-year research project to study the effectiveness of the implementation of the Act and system changes. We know the rest of the country, and indeed the world, is watching what happens here.

We continue to work with our partners to ensure Nova Scotians are provided with knowledge and information regarding this legislation so they can make informed choices. We will ensure optimal end-of-life care is provided to families by optimizing donation, which will contribute to more Nova Scotians being able to live healthier and longer lives after a successful organ or tissue transplantation.

Transformation of the health care system is a rare, rare opportunity. There have been and will continue to be challenges over the next few years, but I remain confident that we will be successful. We have an excellent team at Nova Scotia Health, the IWK Health Centre and the Department of Health and Wellness supporting the Organ and Tissue Donation program, the Regional Tissue Bank and the Multi-Organ Transplant Program as we work towards that goal.

With that, Mr. Chair, I thank you for the opportunity to appear before you and look forward to our discussions today.

THE CHAIR: Thank you, Dr. Beed. That's quite a profound subject matter that we're touching on today, but definitely some inspiring words to hear from yourself, and I wish you well.

At this point, the committee - why don't we do the Q&A? Each caucus will have 20 minutes allocated, after which we'll go to a second round based on the time remaining, so without further ado, I see Mr. LeBlanc is going to kick us off for the PC caucus, please and thank you.

COLTON LEBLANC: Thank you, Dr. Beed, for joining us this afternoon to continue an important conversation on a progressive and transformative policy, the first of its kind in North America. I want to thank you as well for your 15 years of service to the Organ and Tissue Donation Program. You've been there, I understand, since its inception, so thank you.

I'm proud to be a registered organ donor, and I encourage every Nova Scotian to do so as well. The topic of organ donation should start at home, and research of this topic - it was in one of the articles that it should be talked about around our kitchen tables with our loved ones so that they are well informed of our final wishes.

Death and dying is a difficult enough subject to be dealing with on a day-to-day basis, and various cultures and societies deal with it differently. This could be a massive shift for many Nova Scotians, but I do appreciate the positive impact that it does have for Nova Scotians waiting for organ donations and the families of donors themselves.

I'd like to discuss a bit with you, Dr. Beed, some of the education element, and you spoke about it in your opening remarks regarding the public awareness. I guess you see it in TV ads and in social media ads and things like that, but how far of a reach do you believe that this has netted Nova Scotians, on a percentage scale?

STEPHEN BEED: That's an excellent question. The short answer is we're not entirely sure, but we're certainly aware of the need to connect with as broad a population as possible, and to that end, we have made a specific effort to address this topic in the social media realm - in the digital form, if you will, with television advertising, with a campaign the Department of Health and Wellness has been supportive of, and through that we intend to get the message to everybody that we can in Nova Scotia.

There was an initial launch of some of this in July, and starting relatively soon, meaning in the next few weeks, late December, January, we will have another round of advertising to get the message out. Having said that, we realize that that type of a campaign is not going to connect with everybody, and there are historically marginalized groups that may be particularly vulnerable to a law change, if you will, and at the same time may not be relying on these sources of information.

We don't know that for sure, but recognizing that that is a possible risk, we have developed from its inception - we've developed a strategy to specifically reach out to leaders of these marginalized communities so that we can connect with them to inform them of what's happening in trying to address any concerns those communities might have

in reference to the new law or, in a broader sense, we've offered the opportunity to talk about the value of donation in a more specific clinical sense.

There's probably two layers to this conversation. People need to understand there's a new law, for sure, because there is. But what we know from our own experience in this province and what we can learn from other countries is that many people know very little about donation and transplantation at all. Getting them informed about the basics is a priority. Then in the context of that, a conversation around a new law becomes even more relevant.

Knowing that we need to connect with those people was identified as a priority on day one. A strategy to do so has been brought on board with the July blitz and the January blitz. The ongoing conversations with these leaders has proceeded and will continue, and we don't stop on January 18th. We understand that this is a process that's going to require us to continue this for - I don't even know how long, but frankly, as long as people are interested, we're happy to connect with them on that level. It's an important question and we recognize the need to continue that work.

COLTON LEBLANC: I guess I'm afraid that maybe not enough Nova Scotians know the details and the pertinent information regarding this legislation. It is a massive shift in the way that we do organ donation here in Nova Scotia.

Like you said in your initial remarks, there would be a lot of eyes on our province to see how it's going to be rolled out. I wouldn't want to see this program and this initiative being hindered, that we haven't taken sufficient steps to ensure that enough robust awareness campaigns have been done.

Previously when we do our MSI renewals, Nova Scotians received mail directly addressed to them and it goes over the donation process, if they want to be a type one donor or type two or not. Do you believe that type of correspondence should be communicated to Nova Scotians in anticipation of these changes to ensure that Nova Scotians from Yarmouth to Sydney are very well aware of what the change is going to mean for them and their families come January 18th?

STEPHEN BEED: Yes, I do. Again, an excellent question. To that end, we have actually developed a specific pamphlet that I saw the final draft of probably a week or two ago that will be specific dealing with that. It will be information around this new law and will go out to everybody who is renewing their MSI card.

We've also tried to make access to information that people might need by publicizing what's available on our website. We're in the process of developing communication tools that will be going out to family doctors as well, to serve as a conduit to the patients on the front line. It's an important issue that we are addressing through that new pamphlet, but that's not the only thing we will be doing.

COLTON LEBLANC: If memory serves me correctly, I just renewed my health card recently. I may only be getting that renewal and that information in the mail a couple of years down the line. Do you think it would be an appropriate step to ensure that - it's not everybody that has access to a computer or email or Facebook or listens to the radio or watches TV.

To ensure that everybody that has an MSI card in our province, that has access to mail so they would have that information, do you think that we could take the measure now proactively in the weeks ahead and potentially shortly after January 18th to ensure that every Nova Scotian has this information in their hands?

[1:30 p.m.]

STEPHEN BEED: In a perfect world, I think the answer is yes. From a practical point of view, I know the rollout strategy that has this accompanying new renewals is already in place. How to get it to people who, like yourself, may have just renewed - I'm not entirely sure what the process would be, but I think my impression has been, in working with people at the Department of Health and Wellness, is that they're very interested in trying to get this done the right way, and that if it becomes clear that we're missing people and that that kind of a second mail or whatever might be worth it, I'm sure we'll discuss it. Whether that's the best way to connect or not, I don't know.

I think it's an important issue, and that might be a way to solve the problem. We may address it through other means. For example, our strategic connection with front-line family doctors is going to be crucial. If family doctors become supporters and advocates, they're going to be able to connect with patients in their own offices, we would hope, in a way that's even more effective than a pamphlet. A pamphlet is a tool, and it's not something we would discount, but maybe there are other things we're going to bring on board that will be able to connect with people who didn't get the pamphlet, so to speak.

COLTON LEBLANC: I think as leaders in our communities and our province, we can all be champions to promote this program, and I think it's imperative that we do so to increase public awareness through our offices and through the means that we have at our disposal.

I'd like to focus a little bit on education of our front-line workers. We talked about whether it be certainly in the hospital setting with doctors and nurses and respiratory therapists. Has there been any discussion in the pre-hospital setting - for paramedics, for example? When I worked as a paramedic, it was a short discussion about organ donation and the relationship with the medical examiner's office, but is that something to improve to ensure the efficacy of this program - that there's going to be robust and rigorous training for front-line workers in the pre-hospital end in hospital settings?

STEPHEN BEED: We recognize this as absolutely crucial. We have not actualized what we think is necessary, but we have a plan in place to at least partly do that. I think

you highlighted what I would acknowledge is a potential gap, but I think a definition of whether we've been successful or not is going to have to await X number of months when we've rolled out what we have planned and see if there are issues.

I say that in particular reference to some of the very front-line people like paramedics, because we have a strategy to address the needs for hospital-based health care team members. We have initiated conversations with our colleagues in family practice, and it may be that those front-line people need to have more support. We recognize that there are, broadly speaking, two clinical areas where identification of the potential donor is hugely important. One of them is the emergency department, and we in fact had meetings with the emergency department leaders this week to discuss these changes with the hope that we'll be initiating a dialogue with emergency clinicians across the province, and that will include people like paramedics.

If the feedback that we're getting from our regional colleagues in emergency departments is that there are other parts of their health care team that we haven't specifically connected with, we're absolutely willing to do so. You bring up a great point. I guess it's obvious you have a bit of experience in this area, and all I can do is acknowledge that you've identified something that we might not have the full solution for at this point, but we're connecting with leaders in the emergency medicine field, and we're absolutely prepared to develop something if a gap is identified.

COLTON LEBLANC: I guess the discussion that we're having right now regarding public and health professional awareness revolves around that the intent of the program and the changes to the program must happen in tandem with public awareness. In researching other jurisdictions, that's how I gather the success has been significant. That implied consent in this circumstance means that government must do everything in its ability to ensure that it's informed consent.

When I was researching and looking into this topic, I realized that the opting-out process has started. Do you know possibly the number of Nova Scotians that have chosen to opt out?

STEPHEN BEED: Actually, we've been tracking that from the very first day that the opt-out registry was brought on board. It's interesting because extrapolating from what we saw in countries like Wales who recently brought this on board - we expected that we might have 5 and 10 per cent of the population that might opt out. We knew from public surveys what the support for donation was, and so we figured we might have that ballpark.

Here we are, a little bit more than a month away from this law coming into effect and we have about 1,300 people, so a little bit more than 1 per cent of the population who have registered an intent not to donate. The accrual of people in that registry has been relatively constant, so it's not like there was 25 per week and then some strange story in the media generated 500 in a single week or whatever. It has been a relatively small number and sort of a slow constant dribble that have gotten us to a little bit more than 1 per cent.

What's going to happen in January as the law is about to come into effect - maybe there will be a bunch more people who have chosen at the last second. That's possible. I don't know, but our numbers to date have been lower than we expected they would be.

COLTON LEBLANC: Thank you for that response. It's great to hear that the actual number is much less than the expected number.

Can you gauge the amount of public outreach that has been made to the program regarding various questions or concerns that they have? Obviously, there is an abundance of information online, but any direct outreach to the program's office?

STEPHEN BEED: We have organ donor coordinators who are vetting calls on a daily basis from the population at large. Questions around this topic get directed to them. I know that several calls per day end up being vetted. The exact total, I don't know. The number is not trivial, but it's not enormous.

Frankly, I actually wish there would be more. I don't know if that means that there are people with questions who aren't sure how to get the question answered or not, which is why we continue to focus on getting our message out. To date, we have absolutely had queries from the public. I just don't know what the exact number is.

COLTON LEBLANC: I would like to wrap up on one last question. Thank you again, Dr. Beed, for your insight and for joining us this afternoon. In one of the articles I read, it spoke about how - and obviously this is in part how our health care system is designed based on our geography and population statistics - it is based around centralization. Obviously, QEII has more specialized resources and personnel.

They also spoke about the ability to have regional experts, so wondering how you envision that to be rolled out, and if there's time remaining, how this program in Nova Scotia is going to change the landscape or the ability or the program of organ donation across Canada.

STEPHEN BEED: I'm not sure how strict you are on your time. Those are great questions well worth discussing, but they're not a one-minute answer. Should I just answer and keep on going, or are we going to address that later?

THE CHAIR: Go for it.

STEPHEN BEED: We do have a centralized health care system. We recognize that in a population base of roughly 1 million people in a province this size, having some expertise in every regional centre is necessary, but the kind of specialized stuff can only go in one place, more or less, and that's the QEII. That's why our transplant program and donation program is based here, and programs like neurosurgery and cardiac surgery are in one place. That can't and won't change.

However, what we've recognized for some time is that donation opportunities are happening in small centres all across the province. As you recall from my opening, the people who become donors are typically trauma patients - well, they all come to the QEII because of the provincial trauma program, that should stay the same. People who have big bleeds into their head from a stroke, there are lots of people on the periphery who are having bad strokes.

Supporting potential donors in regional centres is something we know we need to do better. We need to get the emergency community and regional intensive care teams more informed about this because some of those potential donors may stay in regional hospitals for a period of time while some of their clinical issues get worked out, and if they need to be transferred to Halifax, we will do so.

Interestingly, there is - and this becomes a more complicated conversation, but there's sort of two routes to donation. Neurological death, which is severe injury to your brain, you're dead - the details of that we can go into if you want to - that's about 75 per cent of the people who become organ donors. There is another way to become an organ donor, and that's donation after cardio-circulatory death. People who become donors through that route often have terrible injury to their brain, but not so bad that they meet clinical criteria for neurological death.

Neurological death is a very specific clinical diagnosis, and there are lots of people who unfortunately have terrible brain injuries and will not have meaningful recovery, but they are not dead. Many families know that somebody in that position would choose to go to comfort care rather than being supported in a hospital environment for weeks, months, years, whatever. In some of those circumstances, we would support a switch to comfort care and allow those people to die.

Well, some of those people might be able to be organ donors if the circumstances are right, and we are having conversations around looking and supporting what we call DCD donation in regional hospitals of this province. We're not ready for it yet, but if you ask me what Nova Scotia's donation program looks like in one or two or five years, I think we will be doing regional DCD. That's an appropriate way to decentralize things and to enable families who are dealing with this crisis to perhaps offer the gift of donation, but stay in their local hospital. That's something that we're talking about, but we're not quite ready for yet.

THE CHAIR: I'm just going to add three minutes to this round of questioning for each of the other caucuses, so 23 minutes on the clock for Ms. Coombes, I believe - I see your hand there. Please and thank you.

KENDRA COOMBES: I know that the topic of discussion today will be the upcoming changes to the model at the Legacy of Life program, but I'm hoping that you'll indulge me while I have you here to answer a few questions about the living donation. Can you explain what living organ donations are done here in Nova Scotia?

[1:45 p.m.]

STEPHEN BEED: With one crucially important caveat: I'm an intensive care physician, I'm an anaesthetist. I've been doing this for a long time. I'm pretty comfortable with that topic, but make no mistake, living donation is really something done by my colleagues. I'm happy to discuss it with the caveat that some of these things I could mess up a little.

Who can be a living donor? I'm very comfortable reporting that living donation of kidneys is happening very regularly here at the QEII. It's a program that is based at the QEII, but it supports living donation for all four Atlantic Provinces. Living kidney donation in the adult and the pediatric world is a very good way to support people with end stage kidney disease, if everything can be arranged.

There are programs in the world that are doing living liver donation. Living liver donation is not the same as living kidney donation. If you look at what they're doing with living liver donation, you're doing essentially an extended right hepatectomy. What that means is, you go into the healthy donor and you take out a very large portion of their healthy liver and give it to a recipient, but healthy people have a remarkable ability to sort of re-grow their liver, if you will. So living liver donation is possible, but as you might imagine, if you're going in to do a large resection of the liver, the complication rate for a big operation like that is high and there is definable mortality. It's uncommon, but there are a small number of people who have died from that operation.

If you're a dad and you need to give part of your liver to your son or your daughter or whoever, sign me up in a blink - no problem. The morbidity associated with it, the mortality risk, I don't care - that's for my son or my daughter. Living liver donor programs are well-established in certain centres. Toronto is, I think, the busiest in the world. We don't do living liver here and, to my knowledge, there is no discussion of developing a living liver donor program here.

Also, in certain centres, for example - I think Toronto is also doing this - living lung has been done in some circumstances where, again, a parent might donate to a child two lobes of their lung. There is a small number of cases where people are donating these organs and they don't have that direct personal connection with a recipient, but when you talk about living donor programs, it's almost always kidney, and in certain specialized places, it's liver and maybe lung.

KENDRA COOMBES: Do you know what the recoveries are like for these living donations?

STEPHEN BEED: Generally speaking, living kidney donors do very well. Most of the time now when you're donating a kidney, you're having the kidney taken out - believe it or not - in these tiny, little holes. It's called a laparoscopic procedure. It is an operation,

but the vast majority of people who are living kidney donors do very well. They recover really quite quickly and they do fine.

The recovery after a liver resection obviously takes a lot longer - certainly weeks. My understanding is that the complication rate for living liver is somewhere in the 30 per cent range. That's not a trivial thing. For a life-saving operation for somebody you're close to, sure, but living kidney is an excellent choice for the right people that goes very well. Living liver might be, but I would defer to my colleagues in Toronto on that one.

KENDRA COOMBES: So as you said, there's a significant recovery with regard to liver donation. That would have a significant amount of time off from work, I'm assuming, the person who did the donation, to make this very generous gift to someone. What kind of supports do you think are needed in Nova Scotia for people who decide to donate a living organ, such as a liver or kidney?

STEPHEN BEED: I'd love to imagine a system where somebody who makes that kind of a gift is supported by whatever programs exist in general for people who are sick, but I don't know the details, to be honest. I just don't.

Philosophically, I certainly think that somebody who's making that decision would be somebody whom I would like to see supported as they recover, but I don't know the details on that stuff.

KENDRA COOMBES: Just a little bit, as you said, of information - so Ontario, Manitoba, Saskatchewan, Quebec all have provisions that include in their employment legislation protected leave for people who decide to make a living donation. Leaves are typically around 13 weeks. Would you agree that this would be a good type of program to have in Nova Scotia, for living donation and for the donors?

STEPHEN BEED: A system that supports somebody who has made that decision is something that I think is a great thing. The details around what support looks like, I think, are things that I don't know the details on. Philosophically, as I say, the idea of supporting somebody who has made that decision makes a lot of sense to me. I just don't know what the details would be.

KENDRA COOMBES: I'll give my time to Ms. Leblanc.

THE CHAIR: Ms. Leblanc.

SUSAN LEBLANC: Thank you, Dr. Beed. I just want to start - I'm going to go back to talk a little bit about the Legacy of Life program again, and I just wanted to say that I too am a proud organ donor, and my family has made that decision. Of course, we made the decision for our children.

I think that one of the most moving and profound moments that I've had as an MLA was the time when we passed this bill - the evening when we passed this bill, and hearing from my colleagues with their personal experiences and others who joined us in the gallery that night. It was truly very special, and it felt like really good work. I thank you for your contribution to all of that.

Here we are. It feels like a million years ago that that bill was passed, but we're getting close to it being implemented now, so I just wanted to go back and ask a few more questions about the education program. Hearing what you've said today, I have to say that I'm surprised that what you've reported is actually the case, because I frankly haven't seen any literature. Maybe I'm on the wrong demographic or something, but I haven't seen any ads. I'd like to ask a few more questions about that, because I want to know a little bit more.

We know for sure that the success of this program will be due to a robust education program. We know that that has been the case in other jurisdictions. When we talk about the robustness, I just want to ask some more specific questions.

You talked about social media. You talked about television. I think you said radio but I'd love to confirm that. Can you just give us a little recap on that first of all, to start?

STEPHEN BEED: Sure. Recognizing the need to connect, the communications specialists in the Department of Health and Wellness have been working to develop a specific strategy, so through my lens, there's a body of clinical information that we would like to make sure gets out there. There's information around the law that needs to get out there. The tools, the mechanism, the most efficient way to do that is something that the communication specialists have been very involved with in crafting a specific plan. The first part of it was rolled out in July, shortly after the announcement in June from the Premier that January was the date. It may have been that in the midst of everything COVID-19, Summer weather - maybe the information that got out there didn't connect with as many people as it would in a different universe. Who knows?

We have continued to make information available through access on the website, but there is a specific launch - I guess that's the right word - and I believe it's the first week of January or the last couple of days of December. I don't know the exact date where the second focused round of this will be launched with the intention of making sure that in those few weeks between then and January 18th, the population get to hear about this.

Why did we do it that way? Well, part of it was because, from a practical point of view, who has a budget to have information going forever. To be honest, in my mind, I was really struck by several conversations I had with colleagues in the U.K. As you probably know, Wales brought this on several years ago, now the United Kingdom is. We've been in contact with the people who walk this walk on the other side of the ocean.

Phil Walton, who is an outstanding guy, basically made the point that people didn't really pay attention until the deadline was getting close. The analogy he used, which almost everybody here can relate to is we all know what the deadline is for paying our taxes. It's the same every year. How many of us do it in January?

His argument was that if you want to put your message out and have it connect, then the timing is relevant. That flavoured the strategy, which is that we need to connect with the population in the beginning, but that focused message needs to be re-delivered around the time that the law is about to come into place and there is a strategy so that come January, we will be seeing and hearing this.

In my mind, I'd love it to be giant billboards everywhere and we're blitzing the universe the way the Americans put political ads out. That would be great. That's not going to happen, I know that. We will trust that the communication experts have a strategy that works. It has been funded and supported, but I think that's just the first part of this.

I didn't mention it before, but it's interesting - I've got two teenage daughters, which reminds me that I'm getting old, but also reminds me of the influence of social media. They don't watch TV. An ad on TV is like forget it, but Facebook or Instagram or Twitter or whatever the new platform is, is something that connects with them. There is a strategy exactly to connect with that universe.

We've been working with a research group. Tim Caulfield is a social scientist lawyer at the University of Alberta who has got a communications research group. We've been working with them since this project started. They are very closely tracking social media in Nova Scotia to identify if the message is getting out, or is the wrong message getting out or whatever. We're using that kind of information to help flavour how we might approach things.

To your point, I don't think our message has been as broadly distributed as we'd like it, but see if you say the same thing on January 19th.

SUSAN LEBLANC: Great point, and I think that's probably true. People forget what they've seen three months ago, but when it's right in front - and I know there's an art to that kind of release.

[2:00 p.m.]

I will say in terms of hard-to-reach populations - I'm just going to give you a little example from my community in which there live many, many marginalized folks and vulnerable folks. Very-hard-to-reach folks, people without internet access, high levels of poverty, some low levels of literacy. Back in the first wave of the pandemic, there was an outbreak of COVID-19 that happened, and so a testing site was stood up at the local community centre. Within days, there was a massive committee that was service organizations and people from Public Health and my office and the local councillors, and everyone was meeting daily about how to get the information about this testing site out to those folks who don't have access to the internet.

I'm telling you, it was a real struggle. I was going around to apartment buildings and handing posters to the property managers to get them to put them up in the windows of the buildings. We have tons of rental properties here. Even then, I think the word did not get out as much as it should have. The numbers at the testing site were quite low in general, I think. So I just want to use that as an example of how really tough it is to reach certain populations, and especially populations who are sometimes cautious of the medical system, as it were.

I want to put that out there. I was wondering if perhaps some of that campaign coming up in January will be direct mail. I think that that might be, not that I want to tell people how to do their jobs, but I want to tell people how to do their jobs. Direct mail would be really useful, but very simple messaging as well.

Wondering if it might include direct mail, wondering if the strategy might include languages other than French and English, and wondering if there will be culturally sensitive education in that information that is put out.

STEPHEN BEED: You make excellent points, and I completely agree with basically everything you said. One of the things that I've dealt with with colleagues around the world who - for example, I do a lot of work internationally on this topic, and some countries are all in, some countries think it's not the way to go.

But one of the things that people bring up is that there are communities that we don't historically connect with, and will they be well-served by this? It's a valid point, and it has framed our strategy from the very beginning. For example, we have, through the Department of Health and Wellness, specifically connected with marginalized communities, the leaders of those communities to try to make them aware of this. How well that gets dissipated amongst those communities, I actually don't know, but we've consciously tried to connect with the leadership in those communities to try to do so.

I know that part of our advertising will be French radio and Arabic radio. The other interesting thing that we've done - and this highlights the fact that people are watching us - within one day of this being announced by the Premier, I got a phone call about an

opportunity to apply for funding for a Health Canada research grant because the opportunity to study what we're doing, what's working, what doesn't work, is something that is a valuable, rare opportunity, and the world wants to know.

We can talk more about that project if you want, but Activity 3, which is one of the ones I'm a co-lead of, specifically focuses on knowledge and attitudes among health care professionals and the public. I'm working with Dr. Robin Urquhart, who's a qualitative researcher at Dalhousie University, to specifically meet in survey settings or small group settings or focus group settings with historically marginalized communities. It has been part of our mandate from day one to connect with those communities, see what we can learn from them, and see if we're closing the loop. And if we are, great, good for us; if we're not, what can we learn from those communities? What do we have to change?

I honestly don't think we're going to be where we need to be on January 18th, not a hope, but are we on the journey to success? Absolutely. Are we committed to continue that because we identify gaps that are important? I'm absolutely on board with that. But I don't know that we're going to be as successful on January 18th as we'd like to. Whether direct mailing connects, it might, I don't know.

SUSAN LEBLANC: I have lots more questions, but I guess I'll ask if we're not there, if we're not where we need to be on January 18th, then what does it actually look like? When you are presented with an instance where someone could be an organ donor, and the family is uncomfortable with that question - and again, I'm in full support of organ donation, but I know that there are people who are scared about it and worried about it. What's it going to look like? If it is the law, but the education campaign hasn't rolled out as well as it needs to have, then what happens on the ground?

STEPHEN BEED: I'm not sure I would agree that it hasn't launched as well as it needed to. It just might be that in spite of what we've identified as our need, maybe the need is exponentially bigger than anyone could have known. I'm prepared to acknowledge that might be the case.

Practically speaking at the bedside, will we encounter a family that just knows nothing about this? It's possible. What I think gets potentially lost in this, and I just have to sort of state this - I know what it's like to be at the bedside with families in distress on their worst day. I've dealt with it many, many, many times. Our objective is to support the family through the worst day. As a colleague told me, our objective is not to increase donation. Our objective is to enable families to make their best decision on their worst day. When we do it well, that is almost always a consent for donation, and that will be the philosophy that we continue to bring to the bedside with the law or without the law.

But the question does change. When we go there on January 19th, the question is, can we talk about what your husband or your dad's wishes were? That's a different question from, do we have your permission for your husband or your son to donate? It is a different question, and it leads to a different conversation. I think our health care team at the bedside

will negotiate this new reality with a desire to increase donation, for sure, but the real desire is to make sure we're supporting this family on their worst day. I'm confident that most of the time that means they say yes to donation.

THE CHAIR: Ms. Miller from the Liberal caucus, please.

HON. MARGARET MILLER: Thank you, Dr. Beed. This certainly is something very near and dear to my heart. As Ms. Leblanc said, it was probably one of the most emotional and satisfying days we've ever had in the House, because it was all-Party support for this bill, and everybody had a story to tell.

Certainly my family has been one of those families that was on their worst day. Our son was killed, he was a police officer killed by a drunk driver 16 years ago. He was declared brain dead, neurological death, and he had never signed a donor card. We didn't know, we'd never had that conversation with him, and we just thought he was the guy who believed in second chances.

So we thought, what a waste, he's 26 years old, very, very healthy, how could you let that hope be buried with him? We were very fortunate that his organs were all able to be donated except for his lungs, because of his lung capacity. I can tell you in the days and years following, it certainly brought us a lot of peace, and we actually heard from some of the donor families.

Where I want to go with my first question is with donor families. Just recently, to turn it back here 16 years later, my husband three years ago had a cornea transplant. About three months ago, he had a second one that failed and then actually was fortunate enough to receive a third cornea, which is still a work in progress, but it's coming along.

I want to be able to reach out to some of those donor families the same way that people reached out to me. I just wonder what you would advise. Is there going to be an expanded program that way? I think when people know how their loved one's gift has impacted your life - what can we do to bring more awareness there and have that happen more?

STEPHEN BEED: Thank you for your story. I've dealt with a lot of donor mums and your voice will echo a million times louder than mine. Nobody can speak to this the way a donor mom can. I can be part of that a hundred times, and I don't know it the way the mum does. Your voice and tragedy that was the death of your son, I think, is part of the reason we do this. In the middle of what is nothing but bad news, maybe something good came from it. I hope 16 years later you feel that way.

How do we get this message out? Part of it is what we're doing in the context of this whole transformation of the donation program. We want to make sure that the system we have is as good as it can be, and it wasn't. It had to be changed and improved. The opportunity to give a voice to families and to maybe enable them to connect with the

recipients whose lives got changed is something we've known has been an issue historically.

Actually, one of the things that changes in the new law is that there's going to be a provision that enables donor and recipient families to connect. There are certain circumstances and so on, but the bottom line is going forward, donor families and recipient families can get connected in a specific sense.

We have an annual celebration, and I would suggest that anybody who isn't sure if this is the right thing to do should show up at the Gift of Life celebration which we hold annually. It's our attempt to thank donor families for the decision they made. We give them a little memento, but it's really about them connecting with other families and hearing recipient stories. If you don't think that the gift of donation has helped donor families, you need to go there and listen to those stories because their voice is real.

The program has to get as good as it can get. The value of that connection is recognized and supported. The voice of people who choose to use it is something that I think we should support going forward.

MARGARET MILLER: I really appreciate those words. One of the things with our experience, too, is as soon as they told us that Bruce wasn't expected to live, they asked us for his organs. He literally wasn't declared brain dead yet. I think they had a good idea, but they weren't quite saying it yet. They asked if we would think of organ donation. I know it has to be done soon, but I just found that a little too early. It was like pushing it a little bit.

I have another lady whom I know from the Mothers Against Drunk Driving organization - where I got involved - and she actually had her death notification phone call and the second sentence after "Your son is dead" was, "Can we have his organs?" She was furious and hung up on them. For years later, she regretted that she had said no because she would have liked to have known that his organs were out there helping somebody.

Are there also provisions? I think this is going to take away some of that conversation because people will have more conversations about organ donation and what they want. Do you think there needs to be a little bit more put into also the training for nurses, or whoever is in that hospital, to be able to approach a family in a more gentle, kind way?

STEPHEN BEED: People watching this may think that that's a planted question because it's such a perfect question. You have just made a perfect argument for why we need the different system than we had in the past.

[2:15 p.m.]

As I alluded to in my opening remarks, we have a system where there's a whole generation of health care practitioners who just don't know much about organ and tissue donation, so the story you provide doesn't surprise me. It disappoints me, but it doesn't surprise me. There is very clear evidence that the way we do this makes a difference. For example, if you look at consent rates around the world, on the low end, we're in the 20-something per cent and in the high end we're in the 85 per cent. There are clearly factors that influence whether somebody says yes or no.

The way a family is approached absolutely influences whether they say yes or no. It's not just the when, it's the how. This gets back to what I alluded to: how do we make families make their best decision on their worst day? To do this, we actually have to have trained professionals who know how to do this and have them supported by a system that has gotten them where they need to get. That is not our past, but it will be our future.

We have changed the expectation for front-line people. We're asking them to simply identify a potential donor, then phone us. That's it, you did your job. We'll take it from there.

I tell this to the residents every year. I have one or two cases a year where I've given the talk around donation and the residents hear it and then a few months later somebody stops me in the hall and says: Dr. Beed, we had this case in emergency the other day and it was really awful. It was sad. It was terrible. The patient died, but I remembered about donation, so I asked the family. They said no, but I asked.

They think success was that they thought about asking. My definition of success in the future is that they thought about this patient as a potential donor and they phoned us, so that the right people who are trained and who are available can support that family through that journey. That's what our program will look like in the future. That's not always what it looked like in the past.

The investment made in changing our program has included increasing the number of coordinators, changing the way they're trained, establishing donation physicians across the province, supporting the system. That experience you describe I hope will be infrequent in the future.

MARGARET MILLER: I just have one more question and then I'll pass it on to my colleague, Ms. DiCostanzo. It's funny how life has gone; it has almost come full circle. My husband has just recently been diagnosed with chronic kidney failure. He was just informed that he's not a candidate for a transplant, so we're going to be dealing with that whole issue coming up in the near future.

My granddaughter who is an 18-year-old university student actually offered to donate a kidney. I just couldn't be more proud that she saw nothing wrong with doing that.

Not that my husband was going to accept a kidney from her. I don't think he ever would have, if he had been a candidate. It just speaks to the whole outlook and how people think about donation. It's like, if they can, they should. I was really proud of her for doing that, even though it ended up that it wasn't something that he could receive anyway.

I had a conversation with a gentleman after this bill was brought in the House and he was angry. It was the first time I've ever seen him angry about anything government did. He said, I have control over my body and my organs, and nobody should tell me what to do. I expect that he will probably register saying that he wants to opt out. He still believes in organ donation, but he just wants to make that choice.

I wonder how many people on that list of people that are opting out basically want the same thing. They just want to make that final choice when the time comes, but they just don't want - for lack of a better word - Big Brother telling them what they can do with their body.

STEPHEN BEED: I think that sentiment in its various forms is something we have to acknowledge. I think we have to respect the right of people who hold that opinion, but there are a few things I would point out. One of them would be, did they get to that place based on the wrong information.

If we inform people of what the real lay of the land is and they still say no, that's their right and we'll respect that.

In many cases, the reason they're saying no is because of some crazy idea in their heads like, if I do that, somebody's going to sell it to some rich guy. Believe me, I've heard that story. Transplant tourism in this world does exist. If somebody thought that "the government is going to take my organ, sell it, and help deal with the provincial debt," I'd probably be against it too.

If that's where you got to because of crazy information, then our obligation is to get them well-informed. At the end of the day, if that's just the way they see the world, we respect it, we give them an opportunity to register to opt out. If you're really worried that you don't want the government telling you what to do with your body, then you have ample opportunity to make it crystal clear: I think this is important and I have registered that I want to be a donor.

We will still have an opt-in registry. It's just that we also have an opt-out registry. The law comes into effect where there is no clearly defined decision on the part of the patient. For all those people who insist on personal autonomy, great, exert it. Register that you do absolutely want to be a donor, and nobody will take that from you.

THE CHAIR: Ms. DiCostanzo.

RAFAH DICOSTANZO: Honestly, this is just like that night at the Legislature. We're almost in tears, absorbing more than we could ever imagine. I'm so grateful to be an MLA today just to hear all this information. We're given so much information as MLAs. It is truly wonderful.

I just have two questions, but first on the same line about education. I was so excited when you said at one point that \$1 million was given to research because Nova Scotia is starting it. I know the rest of the country is watching and would want to learn from us. I know we do the best job.

I've worked as a medical interpreter for 20 years. The two most important things that I've learned is having two patients and following them for over six months to almost a year who had two kidney donations within a week of each other. I actually brought them to the House. That was what Ms. Leblanc was referring to.

It was incredible what I learned - it isn't just an overnight thing that you can become a recipient. It takes three to six months to get your body ready for it, then there is another six to eight weeks of recovery and organ rejection. The time and effect that it has on the family and loved ones who are watching all this is incredible. It is a huge - it will be in my life. I was just the interpreter so I can imagine what it is to the mother and the parents of that child or the child themselves or the adult themselves.

The difficulty is finding the right match, from what I understood. Now that we're going to have more organs, will that make the preparation time and the recovery time shorter and better? Those organs can only last 24 hours or 48 hours. Is that going to matter?

STEPHEN BEED: The work-up time and recovery times are not going to change appreciably because that's physiology. That's kind of the way it is, but you point to a very crucial reality and that is that for whoever is out there who needs an organ, there is a waiting time while you deal with your health issues awaiting the right match.

Clearly, if there are more organs donated, then the chances that you're going to get the right match go up. I would love to think that with a wildly successful program with many more organs available, wait-lists will definitely be decreased. That's our aspiration. Will we get there? I sure hope so. That's my expectation. I'll share with you something that I thought I had emailed you. I'm hesitant to bring it forward because it's extraordinary news, but boy did we set ourselves up.

When we started this conversation around the need to increase donation in Nova Scotia, we had historically been like The Little Engine That Could. I absolutely loved going to national meetings where we had, by miles, the smallest program - it was me and a couple of other people - and we had the best donor rates in the country. I loved it - and we did, for the better part of a decade.

Then other programs put in things that we learned in other countries in the world were successful. They brought those things on board and got very successful and we drifted to the middle, or even the bottom, of the pack. We had 16 donors in 2017. That was our low point. The trend was down. We started to make the case that we have to do something differently.

We've dealt with this by getting support to reboot the entire program with this law. In 2020, the whole world has dealt with a pandemic. Everything has gone sideways, including donation and transplantation across Canada and across the world. We're bringing in deemed consent for the first time in North America in the middle of a bloody pandemic. On the outside looking in, that's bad planning, but it's the cards we were dealt.

Having said all that, we're not even finished 2020 and we've had 32 donors right now. We have a donation rate that is the highest that's ever been recorded in Canada and we're doing it in the middle of a pandemic. We're doing it in a way that I hope is sustainable. I hope we've set a new benchmark.

Getting 20 donors per year was our 10-year sort of normal. I'd love to think that, going forward, 30 or more donors per year is our new normal. That's what the change in the system - as we get ready for this new law. The law is on January 18th, but the transformation of the system has been happening for the last 18 months. I think we're seeing a tangible benefit at the bedside.

We have more donors per million this year than any jurisdiction has ever recorded in Canada and we're doing it in the middle of a pandemic. That's kind of crazy, but it's good. I hope next year is as good but who can tell? If we can be that successful, I'd like to think that the people in our communities won't wait as long. That's my objective.

The other thing that we didn't highlight is tissue donation. There are hundreds - maybe thousands - of tissue donors we miss in this province. About 80 per cent of the tissues transplanted into people in this country are imported from the United States. They cost - I don't know how many millions. We're missing hundreds of tissue donors. I hope that in our new world, organ donation is our new normal and tissue donation dramatically expands as well.

THE CHAIR: Ms. DiCostanzo with two and a half minutes, please.

RAFAH DICOSTANZO: Maybe it will not end up being a question, but just quickly, I always look at the multicultural and the immigrants and how they think about it.

I come from Iraq and my husband is Italian. I was the first one 20 years ago to register but my husband said no because in Italy, a wedding and a funeral is the biggest thing in the world. They celebrate that in a different way than we do here. For me to convince him, and I actually joke in my family that I've donated but he has the right at the

end to say no. That, to me, is wrong. The Premier said Rafah, don't worry, you will be nagging him from up there if he did that to you.

It was just a joke about this, but it's serious. For me, how can I reach all these different multicultural people and religions that see this as very different from how the average Canadian sees it. How do we educate them? As you were speaking about this research, and maybe some doctors who are from those - I call it the 10 - everything that we did with interpreting was the top 10 languages by percentages of population that we have. In this province we have different language needs than B.C. for example. So maybe in each province, in our province we know what the top 10 languages or the top 10 immigrants from which countries.

[2:30 p.m.]

We have a doctor from those countries that goes in and speaks to them, because there's no point if everybody - those parents or those immigrants - will say no when they're faced with it, because they come from that background, as you said, either their organs are donated because of money or because of this. We come from a different country with misconceptions that don't exist here. Can we help increase the numbers of new immigrants donating? I'm not sure.

STEPHEN BEED: We completely agree. Our strategy has been to connect with the immigrant communities specifically, and we're doing that. I actually had a meeting with the Imam at the central mosque in Halifax, and we're developing a connection with faith leaders. Dr. Urquhart, my colleague with Activity Three actually had a meeting yesterday with faith leaders from across the province.

We've committed to having an ongoing conversation with the Islamic community. We have recognized it as a need. We are on the path towards addressing those historical gaps, and recruiting people from those communities is one of the ways we're going to be successful. Dr. Babar Haroon, who is my colleague, is the one that connected me to the Imam. We'll do more of that.

THE CHAIR: Ms. Adams. Six minutes for this round, folks.

BARBARA ADAMS: Thank you, Dr. Beed, for being here today. You will get a sense from everyone here that we are enormously proud of the Premier and this government for bringing this forward. I was actually sitting in the Legislature knowing that a friend of mine's daughter had died waiting for a lung transplant after being on the list for over a year and a half. My first thought was, this is coming too late for her, but hopefully moving forward it will help so many more people.

I used to work on the transplant team in London, Ontario, as a physiotherapist. I also worked in ICU, and I know that sometimes other allied health professionals are part

of the conversation, sometimes with family who are hoping for a miracle that their family member will recover, but they don't.

I know that I as a physiotherapist and Colton LeBlanc as a paramedic have received no communication from our allied health professional bodies. I'm just wondering if there was any attempt to educate the allied health professionals in the province, because there's a good 100,000 of us out there floating around who could be carrying the message and saying hey, you could have this conversation with your family or to call the transplant team.

STEPHEN BEED: Again, an excellent point. We have focused on our physician group in the ICUs and the emergency department and the nursing community within those as our first priority. The need to connect with the ancillary health care communities is important, and to be honest, that's maybe one of the specific things I'm going to take from this call. Maybe we hang up here and we specifically look at who in those communities we have not yet connected with, because I agree with you.

If you worked in the ICU, you understand it really, honest to God, is a team sport. There are a lot of very talented people that all contribute to a good outcome, and getting them all on the same page makes sense. Physicians spend way too little time at the bedside. If I'm with a family for 10 minutes, the nurse is with them for 12 hours, or the physio might be with them for an hour. It kind of makes sense that everybody is on the same page.

BARBARA ADAMS: Wonderful. Thank you very much for that.

When we started the transplant unit at University Hospital, I was a supervisor there and I know that we did an impact analysis to see how many more of the allied health professionals we needed, how many more wraparound services we needed.

There was also consideration way back then - I won't tell you how long ago, but it was many years ago - where there was mental health services for the family members - both those who were receiving the organ, as well as those who have given up the organ. I'm just wondering - especially given that we're in the middle of a pandemic, which has already stressed everyone out - if there has been an impact analysis done on the number of allied health professionals, including mental health services, that will need to be added to the program as you start to do more organ transplants.

STEPHEN BEED: The short answer is no, there hasn't been an impact analysis. We don't have a specific number, but we have recognized for some time that family support can't just be a relatively non-descript letter a few weeks later that says, thank you, your loved one has helped so-and-so.

In fact, as part of our complete reboot, what we have established is a family support liaison who is now part of the Legacy of Life team. That role didn't exist before, but this is part of our new and improved system. Our role going forward with family support will

be to address some of those issues, as well as to help connect donor and recipient families down the road.

We've recognized it as a need and we have something that resembles a solution in place. Whether we need to do more or different things, I'm open to looking at that as it evolves.

BARBARA ADAMS: I know right now we are moving some patients from acute care beds into a hotel because there isn't enough capacity for the rooms in the current acute care beds, especially in metro. I'm just wondering if you can tell us if you have considered the increased need for hospital beds and whether that's going to impact the other surgeries that might be happening in metro specifically.

STEPHEN BEED: In a specific sense, we have addressed the impact of increased donor numbers, mostly on our surgical colleagues, so the total number of increased OR times or post-op beds or clinic slots is something we have tentatively modelled, if we get wildly successful.

Again, as part of the law, we garnered support to reboot the donation program, as well as support for the multi-organ transplant program and the tissue bank. There is support for a transplant nephrologist - we never had one before, but we will; another liver transplant surgeon - we have three, but we need more than that for four provinces; and nursing and ancillary staff in the clinics. All of that is part of a three-year model to increase support for what we hope will be a lot more patients.

Juggling OR time - there's just no way that's easy. The only way we can do this responsibly is for everybody to acknowledge that a donation and transplantation opportunity - that's just a life saving, you've-got-to-do-it-now kind of thing. That's what happens. We juggle the schedule within the limits we have, but nobody says, we're really sorry, but we can't cancel a list. We make it happen and we'll continue to make it happen. Sometimes it's difficult in the moment, but it happens.

THE CHAIR: We'll move to our NDP colleagues with Ms. Leblanc, please.

SUSAN LEBLANC: I just want to go back a little bit on the public education strategy that we were talking about before. It's interesting to hear you say that there is an opt-in and an opt-out. I'm just wondering if you can quickly - for instance, I've signed my donor card. When I get a renewal, whenever that is, I'll continue signing it - is that correct?

STEPHEN BEED: Yes.

SUSAN LEBLANC: These are some short snappers, Mr. Chair, just so you know.

If I don't want to donate, I'm going to go to the registry, opt out, and I'm going to get a new MSI card that says I don't want to donate. Is that correct?

STEPHEN BEED: Basically, yes. You'd be registered in the opt-out registry and your MSI card would reflect that, yes.

SUSAN LEBLANC: I guess my question is, what measure is the Department of Health and Wellness going to use to figure out if we're on the right track with getting more people, so we know that the new program is working? If we don't know what we don't know, then it's hard to know if we're reaching all of the people that need to be reached with the education program? I'm just wondering how the education program will be tracked, measured, or assessed.

STEPHEN BEED: Again, one of the dramatic changes from our historical donation program has been the establishment of basically a database with IT support. As part of the Health Canada project, we're doing a deep dive on what's happened in the last five years.

Every potential donor chart in the province is being reviewed with the establishment of a baseline for system performance, if you will. We're going to have a pretty accurate snapshot, or as accurate as possible, of where we were and a commitment and tools to define where we are and where we're going. The comparison will tell us if we're successful.

I can tell you that if the past 11 months have been any indication, our conversation with colleagues across the province has led to referrals of potential donors that we weren't getting before. Health care teams are recognizing and supporting this in a way we haven't seen before. We are not getting a whole bunch of nasty letters from people that say somebody approached them for donation. Our system is working better.

It's important to point out that the metric that a lot of people want to focus on and define as a new improved successful system is the number of organ donors went up. Clearly, that's hugely important but if the donor numbers didn't change one bit, but we had a better educated staff, evidence that families were treated in a better way and supported around the end of life - even if donation didn't go up a single bit, that's value added. The fact that we are on our path to defining that and, by the way we've almost doubled our donors - that's huge.

SUSAN LEBLANC: I guess the big question is: Can the public strategy that has been created be shared with the committee and the members?

STEPHEN BEED: From my point of view as I sit here, I'm totally okay with that. I don't know what the rules are, but it seems to me like the strategy that the Department of Health and Wellness communications people have would make sense, I think.

From my point of view as a clinician, I'm really focusing on the fact that we've got a message to get out. We have groups that we want to connect with and that's what I think is happening. Whether there are very specific ways to do that, that's the expertise of the

communications people. I have no problem having people look at that, but that's probably a conversation for somebody else.

SUSAN LEBLANC: Hearing what you just said about the outcomes and what success looks like - even though that is the truth, I'm wondering if you do have some targets. Are you hoping for a 25 per cent increase? A 50 per cent increase? Do you have anything that you have benchmarks for?

STEPHEN BEED: I absolutely want us to have, by miles, the best program in the country and I think we're going to. I want to have a program that's made up of a whole bunch of well-trained excellent clinicians and support people, and we're on our way to doing that. I want to have donor numbers that everybody else in the country thinks we made up because they're too good, and that's where I want to be.

[2:45 p.m.]

Realistically, I mean that's a little tongue in cheek, but that's not really tongue in cheek. I honestly think we can, we should, and we will be there. But if you want to learn from the rest of the world, what we have seen is that if you are very successful at 20-30 per cent increase in donor numbers - which is the metric everybody distills this down to - is what has happened in successful programs.

When we developed our initial targets, we were at 17 donors per million and we really thought that if we do a lot of things right, then we hope we're going to get to high 20s in five years. That's what we were really looking at based on models from around the world.

Having said that, we're less than a year into the real work, and we're at about - you know where we are. We're 32 donors already. I don't know what the future holds, but I know that this has been the best year for donation that has ever been recorded in Canada, and it's in the midst of a pandemic. How does that happen?

It happens because we're starting to change culture and we're starting to get a community in our province informed about and supportive of organ donation. We've got a lot of work to do. Having said all of that, which is wonderful, that's not my target. If you look at the best performing programs in the world - Spain, some organ procurement organizations in the United States - they're in the high 40s-50s. Why can't we be there?

THE CHAIR: Mr. Horne, please.

BILL HORNE: It's inspiring listening to you today answering these questions. So many questions we all have are quite similar, but they're different.

I'm interested in, myself personally, I'm a little older than most people here today, and I have type 2 diabetes - somewhat under control, as best I can. I'm just wondering,

what kind of tissues would I be able to donate if that ever comes to? It will someday of course.

STEPHEN BEED: It's interesting to note that there's no age limit for organ donation, and there have been 90-year-old livers successfully transplanted. Livers are remarkably robust beasts. An elderly patient who is in generally good health might very well be assessed to be a multi-organ donor, but as you get older and as you have more comorbidities, of course the chance of being accepted is decreased.

The take-home message is that it's a specific assessment. I've had patients who've had basically everything wrong you can imagine with them: terrible heart, terrible lungs, on dialysis, nothing's working, and that patient donated a liver that was perfect. Take-home message is even with comorbidities, the assessment is made on an individual basis, and when one or more organs don't work, perhaps there's still something that will.

As for tissue, there are slightly different rules, and they do have an age limit for tissue donation, which I believe is 70. But for organ donation, we acknowledge that as you get older it's a little less likely, but there's no specific age cut-off.

BILL HORNE: Dalhousie University produces medical doctors and specialists also. Is their role changing or will change because of this new Act that's been in for a year?

STEPHEN BEED: The graduates that will populate hospitals and clinics across Nova Scotia hopefully are going into practice with a bit more education around this topic than I did, because we're introducing this importance of donation into medical school. It's included as part of their training during residency, and we are part of the network of continuing medical education, and will be in the future so that our clinical colleagues will go into their clinical universe better equipped.

I hope that they understand that this is part of optimal end of life care and that that's an important part of taking care of their patients, so that they bring it up specifically. I don't know if that will happen. I do know that some of the groups, the sort of gatekeepers - the emergency physicians and the doctors in the ICUs - their role will change. We will be asking them to focus on the identification of the potential donor. We're developing an education platform to help them get where they need to get.

BILL HORNE: I understand the federal government is considering similar to what Nova Scotia has been doing. I don't know much about it. I just read a little bit this morning. I'm wondering if you are familiar with it - that they are going to bring a new bill forward.

STEPHEN BEED: I'm not aware of anything federal, but I do know that as we've talked about this over the last 10 years or so, colleagues across the province have had similar conversations, even if the governments in those provinces haven't gone there yet. As soon as we in Nova Scotia had this law, I know that there was serious conversation in

Alberta, Saskatchewan, Prince Edward Island, and I think in Quebec about bringing this on board.

We are being watched as a province and if we can show that we have brought this onboard and that we are in a better place, I would expect that you will have a lot of interest from your political colleagues on how you did it and what they can learn from it. I would not be surprised if we're successful to find that we are the start of what could be quite a change.

THE CHAIR: Thank you, Dr. Beed. Thanks everybody for a wonderful conversation today.

Dr. Beed, this is heavy stuff, but important work. It's truly amazing, the work that you're doing on behalf of everybody. Do you have any closing remarks for the committee?

STEPHEN BEED: I have to thank you for taking the time to bring this topic to this committee because it's not very often that this topic gets the attention that it has in the context of this. That's a good thing.

The point I need to make - and I alluded to it some time ago - ICU is a team sport. I can tell you that I'm the one sitting here, but there have been a ton of people who supported this at the Department of Health and Wellness - Lisa and Nancy have been the primary leads down there. At the level of NSHA, Vicky and especially Cynthia have been my primary advocates; also Kitty with MOTP, and Harold with the Tissue Bank. We've got people at the IWK who have been working tirelessly on trying to make the system better.

We've got my donation colleagues and critical care colleagues. We are evolving into a real team that can support our front-line day-to-day people who are in Legacy of Life. We've got a bunch of coordinators there; Alana is our new manager. This is a good problem, but they're busting their tails. This is a crazy busy year and an amazing number of people have really risen to the challenge.

I get to sit here and we have a conversation, but there are a ton of people in the back that are really doing the heavy lifting.

THE CHAIR: Awesome. Yes, it's important to acknowledge those folks that are working outside of the space that we're in today. Thanks again, Dr. Beed. We're going to buzz through some committee business. You're welcome to stay and join us for it, if you'd like.

STEPHEN BEED: It's not even tempting, no. (Laughter)

THE CHAIR: We'll see you again another day. Happy Holidays and Happy New Year.

STEPHEN BEED: Thanks for your support.

THE CHAIR: Okay folks, a little bit of committee business that I'm just going to buzz through here. To start off, just based on some of the dialogue in the committee, with the committee's consent, I think it might be appropriate based on some of the commentary to send a letter to all three of our caucuses giving the information that we would have received today about the program and the timeline around January - without telling people what to do, encouraging people to share it to align with the timeline that Dr. Beed referenced today.

As well, Ms. Adams made a positive comment about reaching out to allied health professionals. I think that it might be appropriate that we as a committee write to the communications staff to ask if we can connect with allied health professionals. I know Dr. Beed had indicated that he was going to do it anyway. With the committee's consent, perhaps we can draft those two letters and accompanied information. Is that okay?

Mr. LeBlanc?

COLTON LEBLANC: I'd like to speak to the second point, if I may. If you want to make it a motion - is that something that you'd want to entertain?

THE CHAIR: It's up to you. I just think that, with the committee's consent, we can move forward. It'll be a letter drafted by the committee clerk addressed to the caucuses and to the communications staff at the Department of Health and Wellness.

COLTON LEBLANC: I support both initiatives. Sharing that information with our caucuses is very important. I wouldn't mind making the second point a motion. I think after today's conversation and even previously, we all want this program to be successful. We recognize that the program may, one day, affect us, our loved ones, or our families. There has been discussion and possibly some misinformation or insufficient amount of information, whether it be health care professionals that should have this information or everyday Nova Scotians who will be impacted by this progressive and transformative change come January 18th.

I think it would be incumbent on us to write to the communications team of the Department of Health and Wellness to ramp up their efforts. There has been some discussion regarding a plan, but we're not sure what that's going to look like in the next six weeks. I'd like to see targeted correspondence, whether it be a letter or a pamphlet or some sort of correspondence to every Nova Scotian that has an MSI card.

THE CHAIR: For the sake of acknowledging the clock, Mr. LeBlanc, can you make a motion for us to extend by maybe 10 minutes?

COLTON LEBLANC: I'd like to make a motion that we extend the Health Committee meeting by 10 minutes to ensure that we can complete business.

THE CHAIR: Is it agreed?

It is agreed.

I would defer to the committee about that plan, but I think that we need to be mindful that the communications staff has been entrusted to do their jobs. While we can make recommendations and present them with information, I think we need to be mindful that they're doing that good work on behalf of Nova Scotians. If we present that information, perhaps they have the ability to use it as they see fit.

Ms. Adams.

BARBARA ADAMS: I appreciate that everybody today shared that they want this to be successful, but we also want all Nova Scotians to know about this. I think the consensus is that the communications staff have not quite met that bar that we would have expected at this point.

It isn't just that you need to let me know that I am now an automatic organ donor, I have to also have the conversation with my partner and my children and my family so that I can mentally, as well as pragmatically, have a very difficult conversation with families. I think that it's important that we encourage them to do as much as possible, given the short time frame that's left.

THE CHAIR: Ms. DiCostanzo.

RAFAH DICOSTANZO: What I was really hoping was to have time to ask questions, but I didn't. What I wanted is their communication team - the team that's working with Dr. Beed - to produce things that are easy for us as MLAs to share. That was my intention - to ask him to send us things that we can forward through our social media.

Each one of us have 2,000 to 5,000 people that we can reach, but to make it in a way that is a conversation, start the conversation with a little video - they're very good at that. That is what they know how to reach people, but to prepare it for us as all MLAs that we can use.

[3:00 p.m.]

THE CHAIR: Thank you, everyone. I think we've got the essence of the - oh, Mr. Irving, please.

KEITH IRVING: Thanks for sending the motion. I think the intent of the motion is fine, but I do want to recognize - and I think the Chair touched on this. I do know that they are ramping up public awareness leading up to the 18th, so that work is happening, and I also want to recognize that we are not the ones that have a good stance of the resources that they have and the full strategy that they've got for communications, so for us to imply that

we are instructing the Minister of Health and Wellness to do certain items, I'm a little concerned with.

I would like to propose an amendment to say, "move that the committee write the Minister of Health and Wellness and encourage him to ramp up public health awareness and education about the changes." I'm just adding the word "encourage" in there, because I feel we should recognize that they have much work under way and are best positioned to determine where to put their finite resources.

We have to remember communications in the Department of Health and Wellness right now are doing this in a pandemic, and I think we need to recognize that, and I think with the word "encourage", we can convey the interests of the committee, but not be so presumptuous that we know better.

THE CHAIR: Ms. Leblanc, did you have something final to add to that?

SUSAN LEBLANC: I'm fine with the motion and the amendment. I think words are important, and I think Mr. Irving has a point there. But I guess I just wanted to circle back to when I asked Dr. Beed about sharing the strategy with the committee in the first place, and he responded that in his mind, that would be fine but he'd leave that up to someone else.

I just wanted to clarify if we were going to make that request to the department as the committee to have the communication strategy also just shared with us as it is. I may not be speaking to this motion or the amendment, but I just want to get that on the table.

THE CHAIR: I think Mr. Irving made the official motion, if I'm not mistaken. It wasn't my intention to make a motion initially. Ms. Adams.

BARBARA ADAMS: Colton had introduced the motion, and there was sort of an amendment to it, and then a discussion about perhaps adding to the motion to request that the communication strategy be sent to us, which could all be wrapped up into one motion that Mr. LeBlanc started.

THE CHAIR: Okay. My initial commentary was to try to make this less formal than it's turned out to be. I'm sorry for attempting to do that. The initial motion, Mr. LeBlanc - could you clarify what that was?

COLTON LEBLANC: That we, as a committee, write to the Minister of Health and Wellness to ramp up public and health professional awareness and education on the changes to organ and tissue donation program in Nova Scotia effective January 18, 2021, including direct mailouts to ensure the success of the program - that's without Mr. Irving's amendment.

THE CHAIR: The amendment would be to reframed to say ...

COLTON LEBLANC: Encourage.

THE CHAIR: Encourage the department to ramp up. Maybe Mr. Irving, you can clarify that.

KEITH IRVING: I'm just asking to put into that motion that we write to encourage the department to ramp up public health, just a little softer language there, recognizing that they are - well, I've already spoken to it, so we can vote on the amendment and then we can see if Ms. Leblanc wants another amendment.

THE CHAIR: I think what I'd like to do is button those two up, and then see if we have a subsequent motion, if that's agreed.

To the amendment, is there any further discussion?

Would all those in favour of the amendment please say Aye. Contrary minded, Nay.

The amendment is carried.

To the amended motion, is there any further discussion?

Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

Thank you, everybody. Ms. Leblanc, did you want to make that a formal request?

SUSAN LEBLANC: Sure. I guess I'll say I make a motion that the committee request the communication and public education strategy from the department be shared with the committee.

THE CHAIR: Is there any discussion? Mr. LeBlanc.

COLTON LEBLANC: I'll second the motion.

THE CHAIR: Okay. Hearing that, is there any further discussion?

Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

I'll do my best to buzz through the stuff that's on our list here. Thank you, everyone.

The organization chart from the Department of Health and Wellness was emailed to members on November 27th. Is there any discussion on that item?

I have to bring to the committee's attention that the directive to request quarterly updates to this list will expire along with committee business, so we'll need a motion to continue that protocol, if requested. Ms. Adams, I'm seeing a nod for that motion.

BARBARA ADAMS: I would like either yourself or myself, as the person who moved it originally, to make that motion that this be an ongoing activity that the Health Committee receive this update every quarter permanently - not on an annual basis but permanently.

THE CHAIR: Can I bug you, Ms. Adams, to just table that motion for a second and make another one to extend the meeting until 3:15 p.m.?

BARBARA ADAMS: I would be happy to make a motion to extend the meeting until quarter after.

THE CHAIR: Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

I believe Ms. Adams had used the word "permanently". I want to be mindful that we have to consider future General Assemblies or prorogation, so I might defer to our clerk or Legislative Counsel on what the protocol should be here as we incorporate the discussion here. Mr. Hebb?

GORDON HEBB: I'm not totally sure what I'm being asked here.

THE CHAIR: Mr. Hebb, there's been a request to continue with quarterly updates of the Department of Health and Wellness' organizational chart. Given that we're to experience a prorogation, I'm just looking for some direction on what to do or how to frame that request if we're intending to continue that practice as a committee.

GORDON HEBB: I'm not sure that there's really anything that the committee need do. This is part of an ongoing practice of the committee that, I think, just carries on. This is not like the agenda and the business before the committee. I think it's more of an ongoing practice, but if the committee wishes, for assurance, to re-state it, they can, but I don't feel a pressing need for the committee to go do it.

RAFAH DICOSTANZO: I'm just wondering if once a year would not be enough. Four times a year, that's a lot of work and a lot of paper. I don't know if it is a lot of work on the department or not, but once a year for staff changes could probably be enough. I'm not sure.

THE CHAIR: I would note that I think this was a decision that was made previously. Ms. Adams.

BARBARA ADAMS: There are over 20,000 people who work for the Nova Scotia Health Authority and they change on average 10 per cent a year, so they are constantly changing who are in these management positions. I think a year is far too long. It won't be useful information for us to go through it. For those of us who refer to it on a regular basis, once a year is not sufficient.

Since they've been able to do it every quarter, I would like to - I didn't realize that we needed to keep renewing this, but the Chair indicated that it was going to expire, which I didn't realize there was a year time limit on it. Therefore, I would like to make a motion that the organizational charts from the Department of Health and Wellness and the Nova Scotia Health Authority continue to be submitted to the Health Committee on a quarterly basis.

THE CHAIR: Roger that. Is there any discussion on that motion? Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

So for our January meeting, the clerk has already arranged for the witnesses . . .

RAFAH DICOSTANZO: Mr. Chair, I put my hand up three times. I have a motion as well.

THE CHAIR: I'm also trying to get through committee business here, Ms. DiCostanzo. I acknowledge Ms. DiCostanzo.

RAFAH DICOSTANZO: I would like to move that we add a following witness to our next meeting. The topic is continuing care. The Deputy Minister of Health and Wellness and/or a designate - Dr. Kevin Orrell and a representative from Unifor - to our next month's meeting.

THE CHAIR: Mr. Horne.

BILL HORNE: I have a motion that I would like to get in before we're over.

THE CHAIR: On this subject, discussion please. Ms. Adams.

BARBARA ADAMS: In the interest of not running out of time, can I make a motion that we extend the meeting by another 10 minutes?

THE CHAIR: Yes, that will be final extension.

[Is it agreed?

It is agreed.]

BARBARA ADAMS: I just want to be clear. I'm not opposed to having anybody coming in as guests, but you mentioned something about possibly Unifor. You said one or another, but there is union representation and non-representation. Are they both being invited or is one a substitute for the other?

THE CHAIR: Ms. DiCostanzo, could you clarify that, please?

RAFAH DICOSTANZO: They are both being invited.

THE CHAIR: Is there any further discussion? Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

Mr. Horne.

BILL HORNE: I move that pursuant to Section 36 of the House of Assembly Act and pursuant to Resolution No. 2, Section a(i) passed unanimously on June 16, 2017, that this committee meet after the House prorogued for the life of the General Assembly, abiding by the Public Health protocols and continuing with virtual options, if required.

THE CHAIR: Consistent with some of our other committees, just to maintain operations while the House is being prorogued. Is there any discussion?

BARBARA ADAMS: I second the motion.

THE CHAIR: Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

[3:15 p.m.]

The last item I have here is just the acknowledgement, I think we've agreed that in Ms. DiCostanzo's motion that we would add witnesses, the intention is to move forward with our agenda as expected. Our clerk has already arranged for the witnesses to be present, so with the consent of the committee we will move forward with that witness and have an agenda setting meeting.

Ms. Kavanagh, when will our next our next agenda setting meeting be? Will that be in the January meeting?

JUDY KAVANAGH (Legislative Committee Clerk): No, we have several topics left on the current roster if you want to continue with that.

THE CHAIR: Okay, sounds good. We can play that by ear, but for now, we just want to continue with that January witness as planned. Is there any further discussion?

Hearing none, thank you for your patience, your co-operation, your effort today. It was a pretty cool subject, and we've got lots to talk about on that front. Without any further business on our plate, our meeting is adjourned for the day. Thank you.

[The committee adjourned at 3:16 p.m.]