CANADA
PROVINCE OF QUEBEC
DISTRICT OF MONTREAL

No : 500-06-000952-180

SUPERIOR COURT
(Class Action)

WOLF WILLIAM SOLKIN

Representative-Plaintiff

vs.

THE ATTORNEY GENERAL OF CANADA

-and-

THE ATTORNEY GENERAL OF QUEBEC

-and-

THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

DEFENCE OF THE ATTORNEY GENERAL OF CANADA

(Art.170 C.C.P.)

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THE ATTORNEY GENERAL OF CANADA, IN ANSWER TO THE REPRESENTATIVE PLAINTIFF'S ORIGINATING APPLICATION, RESPECTFULLY STATES THE FOLLOWING:

I. ATTORNEY GENERAL OF CANADA'S POSITION WITH RESPECT TO THE REPRESENTATIVE PLAINTIFF'S ALLEGATIONS:

1. The Defendant Attorney General of Canada ("AGC") admits paragraphs 1, 2 and 3 of the Plaintiff's Originating Application ("Application"), except for common issue e) which was incorrectly reproduced.

2. With respect to paragraphs 4, 5, 6 and 7, the AGC takes note of the class action's nature and the criticisms made against the Defendants, but denies their merit.

3. With respect to paragraph 8, the AGC relies on the Transfer Agreement (Exhibit P-2, hereinafter "SAHTA") and denies anything that is inconsistent therewith.

4. With respect to paragraph 9, the AGC admits that the Class Members are or were residents at Sainte-Anne Hospital (hereinafter "SAH"), situated in Sainte-Anne de Bellevue, Quebec, as of April 1st, 2016, but denies the rest and clarifies that the federal government does not have a fiduciary duty or obligation towards the Class Members.

5. The AGC admits paragraphs 10 to 13 and adds that the situation with respect to the Class Members continues to evolve.

6. The AGC admits paragraphs 14 to 19.

7. The AGC has no knowledge of paragraphs 20 to 23.

8. With respect to paragraphs 24 and 25, the AGC admits that the Plaintiff remained a resident of SAH following the transfer on April 1st, 2016, but denies the rest.

9. The AGC has no knowledge of paragraph 26 and adds that the media coverage (Exhibit P-4) cannot be admitted for proof of its content.

10. With respect to paragraphs 27 and 28, the AGC relies on the publications "The Veterans' Voice – La voix des Vétérans" and the minutes of the Veterans' Committee and of the Users' committee and denies anything that is inconsistent therewith.

11. The AGC admits paragraphs 29 to 31.

12. With respect to paragraphs 32 to 34, the AGC relies on the SAHTA and denies anything that is inconsistent therewith.

13. The AGC denies paragraph 35 as alleged.

14. The AGC admits paragraphs 36 to 39 and specifies that, from 1995 to 2016, SAH remained the only VAC-administered hospital across Canada.

15. The AGC denies paragraph 40.

16. With respect to the allegations contained in paragraphs 41 to 55, the AGC relies on Exhibits P-7 and P-8 and denies anything that is inconsistent therewith, and adds that Exhibits P-7 and P-8 are inadmissible for proof of their content and cannot be invoked against the AGC based on parliamentary privilege and hearsay. The AGC denies the rest and specifies that each transfer had its unique circumstances.

17. The AGC denies paragraph 56 as alleged, and clarifies that, prior to April 1st, 2016, VAC did not provide care and services to Resident Veterans, as defined in clause 2.1 of the SAHTA (hereinafter "Resident Veterans"), as a result of a pledge, but rather in its role as SAH's owner and operator.

18. The AGC denies paragraph 57 as alleged.

19. With respect to paragraph 58, the AGC relies on the April 27th, 2012 News Release (Exhibit P-9) and denies anything that is inconsistent therewith.

20. With respect to paragraphs 59 to 64, the AGC relies on the SAHTA and denies anything that is inconsistent therewith.

21. With respect to paragraph 65, the AGC relies on the May 30th, 2016 News Release (Exhibit P-10) and denies anything that is inconsistent therewith.

22. The AGC denies paragraph 66 and adds that VAC's representatives and employees worked to ensure that the transfer be as seamless as possible acknowledging that a change of this magnitude may create some uncertainty and generate some concerns.

23. With respect to paragraph 67, the AGC admits that VAC's representatives organized information sessions and met with the Veterans residing at SAH and their families, but denies the rest as alleged.

24. With respect to paragraphs 68 and 69, the AGC relies on the March 9th, 2016 letter (Exhibit P-11) and the October 12th, 2016 letter (Exhibit P-12) from Minister Hehr, denies anything that is inconsistent therewith and, further states that the federal government indeed provides financial support to ensure that the Class Members receive the level of care and services provided for in Schedule F of the SAHTA.

25. With respect to paragraph 70, the AGC relies on the SAHTA and denies anything that is inconsistent therewith.

26. The AGC denies paragraphs 71 and 72.

27. With respect to paragraph 73, the AGC admits that the Plaintiff expressed himself through the information Newsletter "The Veterans' Voice" but has no knowledge of the rest.

28. With respect to paragraph 74, the AGC admits the reception and the authenticity of the letters (Exhibit P-13), without admitting the content of Plaintiff's letters, and denies anything that is inconsistent therewith.

29. The AGC has no knowledge of paragraph 75 and specifies that the letter (Exhibit P-14) contains the view of a member of Parliament and constitutes hearsay.

30. With respect to paragraphs 76 and 77, the AGC admits the reception and the authenticity of Exhibits P-15 and P-16, without admitting the content of the Plaintiff's e-mails, and denies anything that is inconsistent therewith.

31. The AGC denies paragraph 78 and further adds that VAC complied with its contractual obligations under the SAHTA and has no further obligation towards the Class Members in relation to the delivery of care and services. VAC does not operate the hospital and has no legal authority over employees of the SAH, CIUSSS, RAMQ or MSSS.

32. With respect to paragraph 79 to 83, the AGC relies on the SAHTA and denies anything that is inconsistent therewith.

33. The AGC denies paragraph 84.

34. The AGC denies paragraphs 85 and 86 and specifies that, at no time were the Class Members' health, quality of life or dignity jeopardized.

35. The AGC denies paragraphs 87 to 89.

36. The AGC denies paragraphs 90 and 91 and adds that Class Members are offered care and services in English and French at SAH, and that VAC has no authority over the recruitment, retention and training of CIUSSS employees.

37. The AGC admits paragraphs 92 and 93 for the period preceding the transfer.

38. The AGC denies paragraphs 94 and 95 and specifies that VAC has no authority over the recruitment, retention and training of employees at SAH.

39. The AGC denies paragraph 96, and adds that Exhibit P-17 is inadmissible.

40. The AGC denies paragraph 97.

41. The AGC has no knowledge of paragraphs 98 to 100, relies on Exhibits P-19 and P-20 and denies anything that is inconsistent therewith.

42. The AGC denies paragraph 101, and further adds that the unfortunate incident reported by the Plaintiff cannot be extrapolated to other Class Members.

43. The AGC denies paragraphs 102 and 103 and adds that the allegations contained in the sub-paragraphs a) to q) relate to evolving situations and/or are based on the Plaintiff's personal views. The AGC further states that:

    a) Schedule F of the SAHTA details the components of the care and services and physician availability to maintain the level of care and services;

    b) According to the SAHTA, CIUSSS bears sole responsibility for managing and operating SAH, including the delivery of care and services to the Class Members on a day to day basis;

    c) Changes in the structure of staffing positions following the transfer is operational in nature, falls within the CIUSSS' discretion, and is allowed as long as the level of care and services described in Schedule F is met;

    d) Schedule F does not provide for a level of care and services by medical specialist;

e) The management of a hospital or a long-term care facility is complex and requires modifications from time to time. Its operational structure may change over the years as a result of several factors. The delivery of care and services depends on the available resources within the Quebec health care and services network;

f) For instance, before the transfer, SAH's operational structure and staffing needs were modified and would have been expected to be modified over the years in light of the decline of the number of resident, the increase of their average age, their level of autonomy and their medical condition;

g) At no time were the health, quality of life or dignity of the Veterans jeopardized.

44. The AGC denies paragraphs 104 to 115.

45. With respect to paragraph 116, the AGC relies on Exhibit P-23 and denies anything that is inconsistent therewith.

46. With respect to paragraphs 117 and 118, the AGC admits reception of the Plaintiff's e-mail dated May 23rd, 2018 (Exhibit P-24), like numerous others sent to VAC's officials, denies the rest and further adds that it has no legal or contractual obligation to comply with nor respond to Mr. Solkin's requests.

47. With respect to paragraphs 119 and 120, the AGC relies on Exhibits P-25 and P-26 and denies anything that is inconsistent therewith.

48. The AGC denies paragraphs 121 and 122 as alleged, and clarifies that the global amount remitted by VAC since April 1st, 2016 to the CIUSSS to cover the care and services *per diem* and to the RAMQ to cover the physician availability *per diem* continues to increase.

49. The AGC denies paragraphs 123 to 126.

50. The AGC denies paragraphs 127 to 130 dealing with the liability of the Defendants AGQ, MSSS and CIUSSS and states that :

a) The parties to the SAHTA have taken reasonable means to fulfil their contractual obligations;

b) VAC provides financial support for the maintenance of the level of care and services provided for in Schedule F of the SAHTA;

c) In any event, if Defendants AGQ, MSSS or CIUSSS have breached any obligation towards the Class Members, they would be solely liable for such breach.

51. With respect to paragraphs 131 - 132 and 131 - 132 (sic), the AGC relies on the SAHTA and the *Department of Veterans Affairs Act* (Exhibit P-27), denies anything that is inconsistent therewith and further specifies that VAC has complied with its obligations under the SAHTA, the applicable legislation and any extra-contractual obligation it may have had, that neither the SAHTA nor the law create a fiduciary duty or obligation towards the Class Members, and in any event, at all material times and with respect to all matters pleaded, taking into account all circumstances, VAC's officials, representatives and employees have acted in a diligent, prudent and reasonable manner.

52. With respect to paragraph 133, the AGC admits that in recognition of their service and contribution to the country, the federal government provides financial support pursuant to the SAHTA for the maintenance of the level of care and services, as well as a priority access for eligible Veterans, but denies the rest as alleged.

53. The AGC denies paragraph 134 as alleged.

54. The AGC denies paragraph 135 and further clarifies that the Courts have not recognized a fiduciary duty or obligation towards the Class Members.

55. The AGC denies paragraphs 136 to 138.

56. The AGC denies paragraph 139, and further adds that the Class Members are not entitled to any *per diem* damages.

57. With respect to paragraphs 140 to 146, the AGC admits that the Veterans are extremely proud and honourable individuals who deserve to be treated with dignity and utmost respect, which VAC's officials, representatives and employees did, denies the rest of the allegations contained therein, and further states that the Class Members, or any of them, have not suffered any compensable loss.

58. The AGC denies paragraph 147 and specifies that there is no joint and several liability between the AGC and the other Defendants.

59. The AGC denies paragraphs 148 to 154.

60. With respect to paragraph 155, the AGC takes note of the Plaintiff's proposed answers to the common questions and adds that they are all ill-founded in fact and in law.

61. The AGC admits paragraph 156.

II. AND, IN CLARIFICATION OF THE FACTS, THE ATTORNEY GENERAL OF CANADA FURTHER STATES:

A. Introduction

i. Extra-contractual liability of the Crown

62. As per the authorization judgment, only the AGC's extra-contractual liability towards the Class Members is in dispute.

63. Thus, the Plaintiff is suing the AGC under the *Crown Liability and Proceedings Act*, R.S.C., 1985, c. C-50 as amended («*CLPA*»).

64. In Quebec, the combined effect of the *CLPA* and the *Civil Code of Quebec (C.C.Q.)* is that the Federal Crown is subject to the rules of civil liability set out in section 1457 *C.C.Q.*, subject to public law immunities.

65. Pursuant to sections 3 and 10 of the *CLPA* no proceedings lie against the Crown in respect of any act or omission of a servant of the Crown unless the act or omission would, except for the provisions of the *CLPA*, have given rise to a cause of action for liability against that servant.

66. At all material times and with respect to all matters pleaded, servants of the Crown, namely VAC's officials, representatives and employees adopted the conduct of a reasonable, diligent and prudent person, placed under the same circumstances.

67. Any representations made by VAC' officials, representatives and employees to the Veterans residing at SAH, were done out of a genuine concern for the care and well-being of Veterans in recognition of their service and contribution to the country and do not give rise to any legal obligation.

68. A fiduciary duty is a private common law concept that does not exist in civil law under the *C.C.Q*.

69. Alternatively, the AGC denies that the Crown has a fiduciary duty or obligation towards the Class Members nor that there would have been a breach.

70. The decision to transfer SAH to the Province of Québec is not in dispute.

71. In any event, the decision to transfer SAH is a core policy decision that is immune from civil liability.

72. Any representations made by VAC's officials, representatives and employees to the Veterans residing at SAH were part and parcel of the policy decision to transfer SAH and as such, are immune from civil liability.

73. The SAHTA covers what was intended by the parties to the Agreement. Consequently, the parties' rights and obligations, including the Class Members' rights to the extent there is a stipulation for another, are limited to those provided for in the SAHTA.

74. Canada's obligations under the SAHTA are explicit and the Plaintiff's claim for extra-contractual liability against the Crown cannot have the effect of creating additional obligations that the Plaintiff would like to be attributed to Canada.

75. Even if the SAHTA contains a stipulation for another in favour of the Class Members, said stipulation does not allow the Court to rewrite or modify the terms of the SAHTA and its schedules through an extra-contractual remedy against the AGC.

76. The Class Members, or any of them, have not suffered any compensable loss and, in any event, they would not be entitled to collective recovery.

77. Alternatively, if a compensable loss has been suffered, it is not as a result of any act or omission by VAC's servants for which the Crown can be held liable.

78. The AGC invokes in his favour all applicable public and private law immunities, including section 9 of the *CLPA*.

ii. The Charters (punitive damages)

79. The Charters do not give rise to a positive obligation towards the Class Members.

80. Class Members' rights guaranteed under sections 1 and 4 of the *Quebec Charter of Human Rights and Freedoms*, and section 7 of the *Canadian Charter* have not been infringed.

81. Further, in any event, VAC's servants acted prudently, diligently and in good faith towards the Class Members at all times.

82. The Class Members are therefore not entitled to any punitive damages.

B. A comprehensive legislative framework

83. The *Department of Veterans Affairs Act* provides authority to the Minister of Veterans Affairs to administer Acts of Parliament and orders in council that are not by law assigned to any other federal department or minister for the care, treatment and re-establishment in civil life of Veterans, the care of their dependents and survivors, and such other matters as the Governor in Council may assign.

84. VAC's mandate is to support the well-being of Veterans and their families, and to promote recognition and remembrance of the achievements and sacrifices of those who served Canada in times of war, military conflict and peace.

85. VAC fulfills its mandate and role through the delivery of programs such as disability benefits, financial benefits, rehabilitation, education, and training supports.

86. The programs offered by VAC are prescribed by statutes and their respective regulations. The three main statutes are:

    a) *Department of Veterans Affairs Act*, R.S.C., 1985, c. V-1;

    b) *Veterans Well-being Act*, S.C. 2005, c. 21;

    c) *Pension Act*, R.S.C. 1985, c. P-6.

87. In addition, the following statutes provide benefits to Veterans in specific circumstances:

    a) *Veterans Benefit Act*, R.S.C. 1970, c. V-2;

    b) *Veterans Insurance Act*, R.S.C. 1970, c. V-3;

    c) *War Veterans Allowance Act*, R.S.C. 1985, c. W-3;

    d) *War Services Grants Act*, R.S.C. 1970, c. W-4;

    e) *Returned Soldiers' Insurance Act, The*, S.C. 1920, c. 54;

    f) *Soldier Settlement Act*, R.S.C. 1927, c. 188;

    g) *Children of Deceased Veterans Education Assistance Act*, R.S.C. 1985, c. C-28;

    h) *Veterans' Land Act*, R.S.C. 1970, c. V-4;

i) *Civilian War-related Benefits Act*, R.S.C. 1985, c. C-31;

j) *Women's Royal Naval Services and the South African Military Nursing Service (Benefits) Act*, R.S.C. 1952, c. 297).

88. Disability benefits, additional monetary and non-monetary benefits available to eligible Veterans, survivors and spouses/common-law partners, include the following:

a) Pain and Suffering Compensation;

b) Rehabilitation Services and Vocational Assistance;

c) Income Replacement Benefit;

d) Case Management Services;

e) Caregiver Recognition Benefit;

f) Canadian Forces Income Support;

g) Public Service Health Care Plan;

h) Critical Injury Benefit; and,

i) Career Transition Services;

89. Veterans may also be eligible for other programs, such as treatment benefits, Veterans Independence Program, and Veterans' allowances, for example, Attendance Allowance and Clothing Allowance.

90. VAC's budget for 2019-20 is currently $4.39 billion, of which approximately 90% represents payments to Veterans, their families and other program recipients.

91. As of March 31, 2019, the federal government was financially supporting more than 4,500 veterans in long term care in over 1,200 provincially licensed, regulated or otherwise governed facilities across the country.

92. As per clause 6.1.7 of the SAHTA, VAC retains legislative and regulatory authority with respect to benefits and services offered to Resident Veterans.

93. At all material times and for all matters pleaded, VAC has fulfilled the responsibilities and obligations that are incumbent on the Federal Government with respect to Class Members under its legislative and regulatory authority.

94. VAC's obligation to provide financial support for the delivery of care and services to Resident Veterans to maintain the level of care and services provided for in Schedule F is solely based on the SAHTA, not on any legislation or regulations adopted by Parliament.

95. To sum up, the comprehensive legislative and regulatory framework does not give rise to the conclusions sought by the Class Members in this Application.

C. The transfer of Ste-Anne Hospital to the Province

i. Historical background

96. Built in 1917, SAH was one of nine hospitals established in Canada by the Military Hospitals Commission to respond to the unprecedented influx of sick and wounded soldiers following the First World War.

97. By the 1950s and 1960s, VAC was operating 18 hospitals across Canada.

98. At that time, the Government of Canada introduced universal hospital insurance and the provinces assumed additional responsibility for the delivery of health care.

99. The Glassco Commission, set up in September 1960, was given the following terms of reference, at page 200:

> "... to inquire into and report upon the organization and methods of operation of the departments and agencies of the government of Canada and to recommend the changes therein which [it considered] would best promote the efficiency, economy and improved service in the dispatch of public business".

as it appears from an extract of the Glassco Commission's report filed as **Exhibit AGC-1**.

100. In 1963, the Glassco Commission's report was issued and notably recommended a general Canada-wide policy of transferring Veterans hospitals, which it described as follows at page 194:

> "The policy envisaged is a gradual integration of federal and community facilities and the eventual withdrawal by the federal government from the operation of veterans' hospitals, hostels or homes. There is no doubt that hospital care in provincially supervised institutions has reached an adequate level for any treatment needs of those veterans with service-

incurred disabilities - a class for which the federal government must have the most direct concern ..."

101. The Glassco Commission more specially recommended, at page 195, that:

> "1 No further hospitals be constructed by the government as active treatment hospital for war veterans.
> 2 Progressively, the treatment of veterans with pensionable disabilities be transferred to public hospitals, with the cost borne by the federal government.
> 3 Veterans with major pensionable disabilities, who require chronic or domiciliary care, continue to be a federal responsibility.
> 4 Veterans without major pensionable disabilities now receiving chronic and domiciliary care at public expense be progressively transferred to community facilities under such financial arrangements as may be expedient.
> 5 Active treatment hospitals now operated by the Department of Veterans Affairs, when cleared, be sold and converted into community hospitals under transfer agreements providing preferential admission rights for veterans with pensionable disabilities."

102. Following this report, VAC has undergone a major endeavour to divest itself of its hospitals. The transfer of federal hospitals to provincial governments was done progressively, on a case-by-case basis.

103. Each transfer was the object of a particularized agreement between VAC and the province, taking into account several factors such as the provincial health care system, the human ressources management, the number of eligible Veterans, their age, their level of autonomy and their medical condition, real property considerations and the then applicable legislation.

104. The 80s and 90s brought gradual changes to SAH notably because the number of veterans dropped and their average age increased.

105. On March 6th, 1982, the SAH Liaison Centre was inaugurated. Its mission was to provide Veterans still living at home with support services, care and therapeutic activities aimed at preventing or delaying institutionalization.

106. By 1995, all Veteran hospitals were transferred with the exception of SAH, which remained the 18th and last hospital administered by VAC.

107. In the late 1990's, an attempt to transfer SAH to Quebec was unsuccessful due to the provincial government's lack of interest.

108. In 2001, $131.7 million were allocated by the federal Government to bring SAH up to provincial standards for long-term care facilities ("The Modernization Project").

109. The Modernization Project of SAH was completed in September 2009, resulting in 446 private rooms in an environment suited to address long-term care needs.

110. By 2008-2009, admissions of traditional war services Veterans had peaked and projection showed a decline over the next 10 years.

111. Had there been no transfer, SAH would have needed to close additional units, lay-off employees, reduce the services, close the facility and relocate veterans, as forecasts indicated that there would be fewer than 100 Veterans resident by 2023.

ii. 2009-2015: Going forward with the signature of the SAHTA

112. By then, SAH had a unique clientele with diverse needs, catered to through different facilities:

a) Main Pavillon and Remembrance Pavillon which provide long-term care to Second World War and Korean War Resident Veterans, divided into geriatrics (57 %), psychogeriatrics (28 %) and psychiatry (15 %). Out of 446 available beds at SAH, 33 beds (one unit) never opened following the renovations. The average age of Veterans housed in these units was approximately 87 years old;

b) Liaison Centre (Day Centre) which provides support services for Veterans still living in the community with 130 clients;

c) Operational Stress Injuries (OSI) clinic which provides mental health care for modern-day Veterans with 225 clients.

113. In July 2009, at the invitation of Minister of Veterans Affairs, the Minister of Health for Quebec confirmed the Province's interest in negotiating a transfer of SAH, as it appears from the letter dated July 16th, 2009 filed as **Exhibit AGC-2**.

114. Given that the Government of Canada and the Government of Quebec had agreed to enter into negotiations for the transfer of SAH, an order in council was issued on December 3rd, 2009 to appoint Mr. Richard Neville as Special advisor to the Minister of Veterans Affairs and Chief Negotiator of the SAH transfer project:

"Whereas the Government of Canada is committed to continue responding to the changing needs and demographics of veterans,

including by ensuring an appropriate capacity of long-term care beds and programming for the future ;

Whereas there is a declining federal need for Ste. Anne's Hospital and anticipated increasing need in the Province of Quebec for long-term care beds";

As it appears from Order in council C.P. 2009-1954 and extension of mandate C.P. 2012-1616, C.P. 2013-0410, C.P. 2014-0155, filed *en liasse* as **Exhibit AGC-3**.

115. On April 26th, 2010, the Minister of Veterans Affairs held a press conference at SAH to announce to the residents and their families as well as the employees of SAH the start of discussions with the Quebec Government for the transfer of SAH.

116. The Minister's messages were that the agreement needed to ensure that Veterans continue to receive priority access to SAH and excellent care, that employees be treated in a fair and equitable manner and that the agreement be in the Government of Canada's best interests, as it appears from the Speaking notes for the Honourable Minister of Veterans Affairs - April 26th, 2010 filed as **Exhibit AGC-4**.

117. In preparation for their mandate, the Chief Negotiator, the Director of SAH Transfer project and their team consulted a great number of stakeholders, conducted interviews and held discussion forums with Veterans' organization and association, the SAH Residents' Committee, some Resident Veterans and their families, local Unions, SAH employees, SAH management team and central Agencies. They also visited other previously transferred facilities and reviewed previous transfer agreements.

118. Notably, on September 23rd, 2010, the Chief Negotiator and senior VAC officials held a forum for Veterans to voice their concerns. Issues raised included:

   a) Maintaining the exceptional level of care and services currently receiving Veterans;

   b) Provision of services in both official languages;

   c) Support for expanding current eligibility criteria for admission to SAH;

   d) Keeping the Hospital for traditional and other Veterans, and within federal jurisdiction as long as possible.

119. On December 1st, 2010, a meeting was held between VAC's Chief Negotiator and MSSS's Assistant Deputy Minister to determine further steps and establish the

negotiation process' timeline, as it appears from the letter of the Minister of Veterans Affairs dated November 29th, 2010 and letter of MSSS's Minister dated January 11th, 2011 filed *en liasse* as **Exhibit AGC-5**.

120. On January 17th, 2012, SAH was accreditated by Accreditation Canada in accordance with the Qmentum Accreditation Program and obtained the global mark of 93.4% for the quality of care and services provided to the residents, as it appears from the Accreditation report filed as **Exhibit AGC-6**.

121. On April 27th, 2012, at SAH, the Honourable Steven Blaney, Minister of Veterans Affairs and Doctor Yves Bolduc, Minister of Health and Social Services signed at SAH an agreement in principle on behalf of federal and provincial governments, and provided an update on the Hospital's future, as it appears from the Agreement in principle filed as **Exhibit PGQ-2** and Media Advisory and Minister Blaney Speaking notes and Press Release filed *en liasse* as **Exhibit AGC-7**.

122. The agreement in principle gave rise to a new phase of negotiation where both parties were to finalize detailed discussions of all conditions related to the transfer, including the requirements for maintaining priority access for eligible Veterans, the level of care and services provided to Resident Veterans, the delivery in both official languages, elements related to human resources and evaluation of assets.

123. The negotiation as well as the exchange of information were subject to a confidentiality and non-disclosure agreement.

124. The first transfer target date was March 2013, which was moved to September 2013, to mid-2014 and then to the beginning of 2015.

125. On August 1st, 2014, an order in council was issued with respect to the transfer of SAH that authorized the Minister of Veterans Affairs to enter into an agreement with the Government of Quebec and the Hôpital Sainte-Anne on behalf of the Government of Canada, the whole as appears from a copy of Order in Council P.C. 2014-0902 filed as **Exhibit AGC-8**.

126. On April 1st, 2015, an order in council was enacted to repeal PC 2014-0902 and authorize the agreement between the CIUSSS de l'Ouest-de-l'Ile-de-Montréal instead of Hôpital Ste-Anne, following the coming into force that same day of Bill no 10: *An Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies*, as it appears from Order in Council P.C. 2015-0432 filed as **Exhibit AGC-9**.

127. Throughout the negotiation process, VAC had a proactive communication approach and to the extent possible, kept informed stakeholders, including the

Resident Veterans and their families, using various modes such as: communications from the Chief Negotiator, memos posted on bulletin boards, messages from SAH's Executive Director on the Veterans Voice or the Veterans Newsletter, letters to the residents and their families, *Just the Facts* Website, Open forums and Information sessions, Press releases as well as face-to-face communications, SAH Executive Director's speeches during numerous events, one-on-one meetings between the SAH staff and Resident Veterans and families.

128. In addition, throughout the negotiation process, VAC's Ministers and Deputy Ministers visited SAH several times to speak to Resident Veterans and employees, hear their concerns in relation to the transfer, and attend commemorations and other events.

129. More particularly, VAC's Minister Fantino paid a private visit to the Plaintiff in his room on December 16th, 2014.

130. Ministers from Quebec Government also visited SAH on a few occasions.

131. On or about April 11th, 2015, the Defendants signed the SAHTA.

132. As of April 2015, out of 446 available beds, three units of 33 beds were closed representing 99 beds, and approximately 20 additional beds were vacant.

133. On April 29th, 2015, VAC's officials and representatives held an information session at SAH and informed the Resident Veterans and their families that :

a) The Government of Canada and Quebec signed the agreement paving the way for the transfer of SAH to provincial jurisdiction;

b) SAH is expected to be transferred on April 1st, 2016;

c) Government of Canada will provide financial support for the enhancement of care and services provided at SAH after the transfer;

d) Financial contribution will apply to nursing care and on-duty physicians, professional services and various other services such as pastoral care and recreation;

e) Care and services will be offered in French and English;

f) The transfer agreement provides that eligible Veterans will be given priority access to SAH;

g) Within a reasonable length of time following the transfer, civilians will be admitted to SAH in accordance with terms and conditions established by the Government of Quebec;

h) A transition committee will be set up and operate for three years after the transfer date to monitor and ensure that the conditions and obligations set out in the agreement are met and to support the smooth transfer of SAH to Quebec health and social services network;

i) Lieutenant-General (retired) Michel Maisonneuve will sit on the Transition Committee as Veteran Representative.

The whole, as it appears from the Summary of information given to residents/clients and their family members on April 29th, 2015, dated May 6th, 2015 filed as **Exhibit AGC-10**.

134. During this information session, the main issue raised by the Resident Veterans was the fact that parking for visitors would no longer be free but would cost $3.00 per day (clause 6.2.12 of the SAHTA). This issue was resolved and the parking for visitors remained free.

135. The Office of the Veterans Ombudsman would continue to represent the interests of Veterans and ensure that Veterans and their families are treated fairly and have access to the programs and services that contribute to their well-being. However, the decision to have an ombudsman on site at SAH, as it was the case when SAH was administered by VAC, was to be made by the Government of Quebec.

136. On May 2015, SAH's Executive Director provided the following message to the residents and their families :

> "I am aware that a change of this magnitude is not without generating concerns and anxiety, but rest assured that, in the coming months, we will continue to do our best to ensure that this transfer be as seamless as possible. We will also keep you informed on new developments on the subject."

as it appears from the Residents' newsletter of Ste Anne Hospital dated May 2015 filed as **Exhibit AGC-11**.

iii. The implementation phase of the SAHTA 2015-2016

137. The implementation of the SAHTA was very complex and multi-faceted. It required several steps to be taken by the parties to the SAHTA.

138. Prior to the transfer, due to applicability of National Joint Council Work Force Adjustment Directive (WFAD)[1], employee age and seniority, challenges associated to SAH's geographical location and postponement of the transfer date, VAC's management team made assumptions that staff departure rate would be at least between 20% to 30%.

139. VAC took actions in order to maximize the retention of staff at SAH:

a) Staffing determinate employees in indeterminate positions;

b) Asking Quebec to offer part time employees the possibility of filling out a form to show their interest in working additional hours or on call for replacement;

c) Requiring that all SAH employees have their cardiopulmonary resuscitation and proficiency in designated securities duties certification up to date and supporting continuous education.

140. Pursuant to section 23.2 of the SAHTA, Quebec and the CIUSSS were to notify Canada no later than November 1st, 2015 if a postponement of the April 1st, 2016 date for the transfer of SAH was required, if the CIUSSS was not able to integrate SAH into its organizational structure.

141. On or around November 1st, 2015, the MSSS confirmed that the transfer would take place, as planned, on April 1st, 2016.

142. Under the terms of the SAHTA (section 13 and Annex I), the CIUSSS had to send VAC the offers of employment destined to SAH employees no later than the 150th day preceding the transfer date.

143. On November 2nd, 2015, the offers of employment received by VAC in sealed envelopes around a week prior were handed out to SAH employees (indeterminate and determinate) by VAC's human resources and management team in the auditorium. These were accompanied by a letter from VAC to help employees make an informed decision. In addition, employees were kept informed through various information sessions and news releases.

144. Quebec offered positions to all SAH employees, with the exclusion of the management team and the physicians. Employees were required to provide

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[1] A workforce adjustment is a situation that occurs when the services of one or more indeterminate employees will no longer be required beyond a specified date due to a lack of work, the discontinuance of a function, a relocation in which the employee does not wish to participate or an alternative delivery initiative.

responses by January 1st, 2016. Almost all of the offers did not meet the criteria set out in the WFAD.

145. On November 25th, 2015, a meeting occurred between the CIUSSS's President and CEO and SAH's Executive Director to discuss various issues, such as, the more demanding pre-requirements qualifications under the Quebec regime for orderlies, as it appears from the letter from CIUSSS dated December 14th, 2015 filed as **Exhibit AGC-12**.

146. As a matter of fact, out of the 1024 employees of SAH who received an offer, 629 accepted (61,4%) and 395 refused. Within the classification for nursing, 251 employees received an offer, 164 accepted (65.3%) and 87 refused; within the classification sanitary, dietetic and orderlies, 523 employees received an offer, 335 accepted (64%) and 188 refused, the whole as it appears from the tracking transition chart filed as **Exhibit AGC-13**.

147. Staff recruitment started early February 2016 given Quebec's request for an additional payment of $16.3 million for buildings repairs, out of which Canada accepted to pay $9.8 million before the transfer date of April 1st, 2016, the whole as it appears from the letters dated January 11th, January 29th and February 1st 2016 filed *en liasse* as **Exhibit AGC-14**.

148. In order to fulfill the vacant positions, VAC and CIUSSS worked together to recruit staff. To that end, the following activities were held at SAH with CIUSSS representatives :

a) A job fair on February 10th and 11th, 2016, with hundreds of attendees;

b) An open house on February 17th, 2016 ;

c) A knowledge exchange activity on February 18th, 2016 ;

d) Selection interviews of external applicants;

e) Orientation sessions of new employees.

149. Between January 1st, 2016 and the Transfer date, VAC accepted to hire 96 and rehire 13 more for the duration of the transition to train them before the transfer and/or secure their retention. The objective was that new employees would be operational on day one of the transfer and be acquainted with Resident Veterans.

150. The Honourable Minister Hehr visited SAH on March 14th, 2016 to show support to Resident Veterans and employees and meet residents and key committee members.

151. As the actual transfer was approaching, Resident Veterans' main concerns related to the due date for the payment of the accommodation expenses under the Quebec administration (payable the first day of the month instead of the last day) and the cost for the hairdressing and barber services which would now have to be supported by Resident Veterans.

152. Both concerns were resolved to the satisfaction of the Veterans as VAC decided to forego the payment of the accommodation expenses for the month of March 2016. VAC also undertook to assume the costs related to the hairdressing and barber services offered at SAH after April 1st, 2016, as it appears from SAH Executive Director letter of March 3rd, 2014 already filed as and the memorandum-Transition dated March 24th, 2016 from SAH Executive Director filed as **Exhibit AGC-15**.

153. VAC organized ongoing meetings and visits for CIUSSS' representatives with the Resident Veterans and their families, Residents' Committee members and the employees, and introduced the future Quebec ombudsman to the residents.

154. At the last hour on March 31st, 2016, the Deputy Minister of Veterans Affairs, SAH Executive Director and part of her management team were present at the hospital for federal employees completing their last shift in that capacity.

155. On May 30th, 2016, Quebec and Canada issued a common press release to announce the official transfer of SAH, a long-term care centre that welcomed new residents starting April 15th, 2016, as it appears from the press release filed as **Exhibit AGC-16**.

D. VAC's limited role after the transfer

i. SAHTA

156. Pursuant to section 4 of the SAHTA, its purpose is to establish the terms of the takeover of the management, operation and maintenance of SAH by the CIUSSS and of the transfer of the immovable, movable, and supplies and inventories by the Government of Canada to the CIUSSS.

157. Pursuant to subsections 6.1 b) and 6.2.1, the Government of Canada agreed to cease managing, operating and maintaining SAH on the transfer date. These responsibilities were devolved to the CIUSSS as of that date.

158. Pursuant to subsection 6.1.5, the Government of Canada has to pay monthly *per diems* for care and services as well as physician availability.

159. Pursuant to subsection 6.2.7, following the transfer, representatives of VAC are given access to SAH solely for the purpose of enabling VAC to fulfill its obligations and functions towards Resident Veterans, as provided by the legislative and regulatory framework. Such access requires obtaining the CIUSSS' consent, upon receipt of a written access request submitted by VAC at least 24 hours prior to the visit, and informing the Government of Quebec.

160. Under the terms of the SAHTA, services to Class Members are to be offered by the CIUSSS in English and French in accordance with provincial legislation applicable to the provision of health care of services.

ii. VAC's financial contribution

161. Pursuant to subsection 6.1.5 a) of the SAHTA, the *per diem* funding for care and services is payable monthly according to the number of beds occupied by Veterans at SAH, upon receipt of an invoice issued by the CIUSSS.

162. Pursuant to subsection 6.1.5 b) of the SAHTA, the physician availability *per diem* is paid upon receipt of an invoice issued by the CIUSSS directly to the RAMQ, in accordance with the letter dated June 6th, 2016, addressed to the Assistant Deputy Minister of Veterans Affairs, as it appears from **Exhibit AGC-17**.

163. Since the transfer, VAC has complied with its funding obligation and paid all invoices in due course.

164. In all and for all, up to October 16th, 2019, the federal government has paid just over $60 million in costs related to the SAHTA , of which $39,073,412.71 were paid as *per diems* in accordance with subsection 6.1.5 and $9,409,901.00 for financial assistance to compensate budget shortfall in the CIUSSS operating budget in regard to SAH activities in accordance with subsection 6.1.8 c) of the SAHTA, and $73,677.72 for haircuts.

165. The SAHTA does not provide for an obligation or a right allowing VAC to audit the allocation or the use of the funds paid by VAC to the MSSS and/or the CIUSSS under the SAHTA.

166. Under no circumstances should the AGC be obliged to once again pay the *per diems* provided for in the SAHTA.

iii. The Transition Committee

167. Pursuant to the section 9 of the SAHTA, the Defendants established a transition committee at SAH for a period ending no later than 3 years after the transfer date.

168. The *Transition Committee Mandates and Terms of Reference,* Schedule G to the SAHTA provide that the Committee was co-chaired by VAC with at least one additional representative of VAC and one Veteran representative, namely Lieutenant-General (retired) Michel Maisonneuve, sitting on the Committee.

169. The Transition Committee's mandate was, among other things, to « veiller au respect du maintien de niveau des soins et services pour les anciens combattants, tel que prévu à l'Entente de cession. »

170. In fact, from June 14th, 2016 to March 22nd, 2019, representatives of VAC participated in Transition Committee meetings, expressed concerns and were involved with finding solutions to issues raised, notably with respect to:

   a) The difference between the federal and provincial medical coverage (September 28th, 2016; February 8th, 2017);

   b) Staffing (December 7th, 2016; February 8th, 2017; June 9th, 2017; October 23rd, 2017);

   c) The opening of a VAC office at SAH, with the presence of a VAC representative on site, to reassure the Veterans and their families of VAC's continued commitment to offer benefits and services (December 7th, 2016; June 9th, 2017; October 23rd, 2017; May 24th, 2018);

   d) Timing of the civilian population's integration at SAH (December 7th, 2016; October 23rd, 2017; May 24th, 2018);

   e) Cost of parking (June 9th, 2017);

   f) Preferred beds for new Veterans (October 23rd, 2017; May 24th, 2018);

   g) SAH employee training with respect to the particularities of the Veterans clientele (March 22nd, 2019);

   the whole as it appears from "Compte-rendus Comité de transition no 1 to 8" already filed as **Exhibit PGQ-4**.

171. The Transition Committee ended its mandate on March 22nd, 2019.

iv. VAC's further involvement for the well-being of Resident Veterans

172. VAC, the MSSS and the CIUSSS agreed to put in place a new joint committee VAC/CIUSSS, with the participation of Major-General Éric Tremblay (retired) as the Resident Veteran's representative, with the mandate of :

> Assurer les suivis nécessaires concernant le bien-être des vétérans hébergés et de leurs familles à HSA, et proposer des recommandations conjointes et collaboratives au CIUSSS et ACC visant à apporter des solutions novatrices.

as it appears from the "Fiche de proposition de mandat", **Exhibit AGC-18**.

173. Further to the transfer of SAH, VAC's officials met on occasion with the Province and the CIUSSS and conducted various follow-ups with respect to the status of SAH, such as:

a) On November 3rd, 2016, VAC Deputy Minister W. J. Natynczyk wrote to Michel Fontaine, Deputy Minister, Santé et services sociaux, regarding staffing issues, quality of care concerns and the possibility of opening a VAC office at SAH, as it appears from the letter of W.J. Natynczyk to Michel Fontaine (November 3rd, 2016), **Exhibit AGC-19**;

b) On October 3rd, 2017, VAC Deputy Minister W. J. Natynczyk wrote to Michel Fontaine, Deputy Minister, to raise his concerns with respect to staffing, the wait time to consult a specialist, the Clinic for post-traumatic stress syndrome and other operational stress injuries related to military service and to bring up Resident Veterans' grievances with respect to healthcare professionals on site, particularly mental health professionals, as it appears from **Exhibit AGC-20**;

c) On August 28th, 2018, Deputy Minister W.J. Natynczyk wrote to Deputy Minister Michel Fontaine bringing to his attention SAH residents' concerns with respect to care provided, as it appears from the letter **Exhibit AGC-21**.

174. In April 2017, VAC appointed a liaison officer at SAH, whose mandate consists of ensuring close monitoring of residents' well-being on site, as it appears from the job description document filed as **Exhibit AGC-22**.

175. In addition, VAC's officials visited SAH to meet with the Residents' Committee, some Resident Veterans, their families and the Transition Committee Veteran Representative, participate in commemorative events and Town halls, train SAH employees with respect to the particularities of the Veteran clientele and exchange with SAH executives.

E. SAH and Mr. Solkin's personal experience

i. The situation at SAH

176. For at least the last two years prior to the date of transfer, recruitment and retention at SAH had been a challenge for VAC given the geographic location of the hospital, language requirements, the continuous postponement and uncertainty of the date of transfer. VAC had to hire staff from agencies especially during summer time, and faced issues of workforce stability and availability.

177. In October and November 2016, 108 Veteran residents from the Main and Remembrance Pavilions at SAH were surveyed on their perspective on their quality of life. The results revealed that quality of care and the staff's caring and respectful approach were SAH's strongest assets, while weaknesses had to do with residents' interpersonal relationships, the whole as it appears from the "Rapport – Sondage sur l'expérience client, Hôpital Sainte-Anne, janvier 2017", **Exhibit AGC-23**.

178. Throughout the 992 Royal Canadian Legion (RCL) visits to SAH Veterans completed between April 2016 and March 2019, only eight Veterans raised an item during the course of the visit and conversation with a RCL volunteer, as it appears from a Summary document entitled "Ste-Anne's Hospital, Ste. Anne-de-Bellevue, QC" dated July 5th, 2019, filed as **Exhibit AGC-24**.

179. Through their presence and their commitment, the volunteers have enriched the life of the Veterans residents at SAH by improving their well-being.

ii. The Plaintiff's personal experience upon admission at SAH

180. In April 2013, VAC admitted the Plaintiff in the geriatrics section, where he has been living ever since.

181. There is no evidence that care and services were not provided to the Plaintiff following the transfer of SAH.

182. Both before and after the transfer, the Plaintiff complained about several issues notably through emails addressed to various stakeholders or directly to the medical staff.

183. On May 26th, 2015, prior to the transfer date, the Plaintiff filed a complaint with VAC's ombudsman requesting that disciplinary sanctions be taken against the then SAH Executive Director in light of her alleged conduct towards him in the context of the SAH Residents' Committee election process.

184. VAC conducted an investigation, and formally responded to the Plaintiff on October 19th, 2015, concluding that hospital leadership did not act improperly but rather acted for the welfare of the entire resident population, the whole as it appears from VAC Ombudsman's documents related to the Plaintiff's complaint filed *en liasse* as **Exhibit AGC-25.**

185. Since the date of the transfer of SAH, VAC' officials showed responsiveness to the Plaintiff's grievances within the context of their limited role as per the SAHTA and the legislative and regulatory framework.

186. The Plaintiff has not suffered damages, and alternatively, the damages he alleges having suffered are excessive.

187. There is no causal link between the alleged fault of any Crown servant and the damages claimed.

III. COMMON ISSUES

188. In summary, the AGC proposes to answer the questions described in the authorization judgment as follows:

a) Do the Defendants Attorney General of Quebec and the CIUSSS have contractual obligations towards the Class Members under the Transfer Agreement and if so, which ones and is there a breach of such obligations?

- The AGC does not take position on the issue of whether the AGQ and the CIUSSS have contractual obligations towards the Class Members. However, the Defendants have taken reasonable means to fulfil their respective contractual obligations under the SAHTA;

- In any event, if Defendants AGQ, MSSS or CIUSSS have breached any obligation towards the Class Members, they would be solely liable for the damages, if any, caused by such breach.

b) Does the Defendant Attorney General of Canada have any extra-contractual obligations towards the Class Members and if so, which ones and is there a breach of such obligations?

- The AGC has no extra-contractual obligations towards the Class Members;

- Assuming this is the case, which is expressly denied by the AGC, there is no breach of such obligations.

c) If there is a breach under question a) or b), did such breach cause the Class Members, or any of them, damages and if so, what kind and to what extent?

- Assuming this is the case, which is expressly denied by the AGC, such breach has not caused the Class Members, or any of them, damages.

d) Are the Defendants jointly and severally responsible to pay damages to the Class Members, or any of them?

- The Defendants are not responsible to pay damages to the Class Members, or any of them, and there is no solidarity between the AGC and the other Defendants.

e) Considering that the Plaintiff confirmed that there is no lis pendens with the class action Le Conseil pour la Protection des malades et Daniel Pilote c. CIUSSS de la Montérégie-Centre et al. (500-06-000933-180), have the Defendants breached the Class Members rights to dignity and honour protected by the Quebec Charter of Human Rights and Freedoms or the rights to life, liberty and security protected by the Canadian Charter of Rights and Freedoms? If so, are the Class Members, or any of them, entitled to damages as a result, of what kind and to what extent?

- The AGC did not breach the Class Members rights to dignity and honour protected by the Quebec Charter of Human Rights and Freedoms or the rights to life, liberty and security protected by the Canadian Charter of Rights and Freedoms;

- Assuming this is the case, which is expressly denied by the AGC, such breach does not cause the Class Members, or any of them, damages.

THEREFORE, THE DEFENDANT, THE ATTORNEY GENERAL OF CANADA, PRAYS THIS HONOURABLE COURT TO:

DISMISS the Representative Plaintiff's Originating application, the whole with costs, including experts costs.

MONTREAL, October 25th, 2019

Attorney General of Canada

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PROVINCE OF QUEBEC
DISTRICT OF MONTREAL

No : 500-06-000952-180

S U P E R I O R C O U R T
(Class Action)

WOLF WILLIAM SOLKIN

Representative-Plaintiff

vs.

THE ATTORNEY GENERAL OF CANADA

-and-

THE ATTORNEY GENERAL OF QUEBEC

-and-

THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

LIST OF EXHIBITS IN SUPPORT OF THE DEFENCE OF THE ATTORNEY GENERAL OF CANADA

Exhibit AGC-1: Extract of the Glassco Commission's Report dated 1963 (General introduction, chapter 15: Health services).

Exhibit AGC-2: Letter from MSSS's Minister to the Minister of Veterans Affairs dated July 16th, 2009.

Exhibit AGC-3: Copies of Order in council C.P. 2009-1954, Order in council C.P. 2012-1616, Order in council C.P. 2013-0410 and Order in council C.P. 2014-0155, filed *en liasse.*

Exhibit AGC-4: Speaking notes for the Honourable Minister of Veterans Affairs dated April 26th, 2010.

Exhibit AGC-5: Letter from the Minister of Veterans Affairs to MSSS's Minister dated November 29th, 2010 and letter from MSSS's Minister to the Minister of Veterans Affairs dated January 11th, 2011 filed *en liasse.*

Exhibit AGC-6: Accreditation Report of Sainte-Anne Hospital dated January 17th, 2012.

Exhibit AGC-7: Media Advisory dated April 26th, 2012, Minister Blaney Speaking notes and Press Release dated April 27th, 2012 filed *en liasse.*

Exhibit AGC-8: Copy of Order in Council P.C. 2014-0902.

Exhibit AGC-9: Copy of Order in Council P.C. 2015-0432.

Exhibit AGC-10: Summary of information given to residents/clients and their family members on April 29th, 2015 dated May 6th, 2015.

Exhibit AGC-11: Residents' newsletter of Ste Anne Hospital dated May 2015.

Exhibit AGC-12: Letter from CIUSSS to SAH Executive Director dated December 14th, 2015.

Exhibit AGC-13: Tracking Transition Chart.

Exhibit AGC-14: Letter from MSSS's Deputy Minister to Veterans Affairs' Deputy Minister dated January 11th,2016, letter from Veterans Affairs' Deputy Minister to MSSS's Deputy Minister dated January 29th, 2016 and a letter from MSSS's Deputy Minister to Veterans Affairs' Deputy Minister dated February 1st 2016 filed *en liasse.*

Exhibit AGC-15: Memorandum-Transition from SAH Executive Director dated March 24th, 2016.

Exhibit AGC-16: Joint Press Release from MSSS and Veterans Affairs dated May 30, 2016.

Exhibit AGC-17: Letter from MSSS's Deputy Minister to Veterans Affairs' Deputy Minister dated June 6th, 2016.

Exhibit AGC-18: Fiche de proposition de mandat du comité conjoint ACC/CIUSSS.

Exhibit AGC-19: Letter from Veterans Affairs' Deputy Minister to MSSS's Deputy Minister dated November 3rd, 2016.

Exhibit AGC-20: Letter from Veterans Affairs' Deputy Minister to MSSS's Deputy Minister dated October 3rd, 2017.

Exhibit AGC-21: Letter from Veterans Affairs' Deputy Minister to MSSS's Deputy Minister dated August 28, 2018.

Exhibit AGC-22: SAH Liaison officer description job document.

Exhibit AGC-23: Rapport – Sondage sur l'expérience client, Hôpital Sainte-Anne, dated January, 2017.

Exhibit AGC-24: Document prepared by Veterans Affairs Health Care Program Directorate, entitled "Ste-Anne's Hospital, Ste. Anne-de-Bellevue, QC", dated July 5th, 2019.

Exhibit AGC-25: Veterans Affairs Canada Ombudsman's documents related to the Plaintiff's complaint, dated May 26th, 2015 filed *en liasse*.

MONTREAL, October 25th 2019

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GENERAL INTRODUCTION

The reports contained in the following series are all concerned with specific services which citizens and residents of Canada (and, sometimes, of other countries) receive as individuals from the federal government. In effect, these reports—and those in Volume 4, "Special Areas of Administration"—represent a distinct break from the approach that characterized the first two volumes, "Management of the Public Service" and "Supporting Services for Government".

In the thirteen preceding reports, your Commissioners have dealt with the general requirements of administration in the federal government. In this generalized treatment, the essential question has been: what are the needs of efficient, economical and effective administration common to all parts of the public service?

From the outset of the inquiry, however, your Commissioners recognized that an examination of the general aspects or functions of management and its supporting services would leave unanswered many questions of organization and administrative practice. The functional approach had obvious advantages: it permitted the use of fewer, smaller and highly specialized investigating groups, and was likely to be speedier; it also permitted a more unified analysis of government administration and, at the same time, allowed comparisons to be drawn more readily between the different ways in which various departments and agencies met like problems. In view of these advantages, the major research effort was directed into such functional studies, with the results submitted in the first thirteen reports. But it is clearly

necessary to take account of the diversity of government activities and to ask: how do the various operations differ in purpose and character, and what bearing do these differences have on the choice of organizational forms and administrative practices?

The ultimate aim of all government activity is the satisfaction of public wants and the promotion or safeguarding of public interests at home and abroad. Historically, the principal tasks involved have been the maintenance of public order and national security, and the conduct of international relations. Your Commissioners have not investigated the traditional instruments for the preservation of public order—the judiciary and police—except to the extent that general aspects of administration were examined in the Royal Canadian Mounted Police. However, special problems encountered in the administration of national defence and the conduct of external relations—both of which have been profoundly affected by events of recent decades—are considered in the fourth volume of reports.

Since Confederation, the federal government has been increasingly engaged in new tasks: defining goals for the economic, social and, to a lesser extent, the cultural development of the country, and devising means by which those goals can be attained. The result has been the emergence, in Canada as elsewhere, of "the public service state". The process has been gradual and largely unplanned, with a high degree of experimentation in and improvisation of organizational forms and administrative practices. And because Canada has a federal constitution, designed at a time when most of this growth could not be foreseen, it has been a process in which the federal and provincial governments alike have participated, with indistinct and shifting lines separating their respective interests and activities.

The reports that follow do not pretend to examine exhaustively the many services being provided to the Canadian public by the federal government. The large services operated on commercial lines—Canadian National Railways, Trans-Canada Air Lines, and Canadian Overseas Telecommunications Corporation—are again excluded. The Unemployment Insurance Commission and National Employment Service, being the subject of inquiry by another body, are also ignored in this volume. The minor services identified in the course of the present inquiry are too numerous to permit individual treatment, and are dealt with generally in a single report on *Miscellaneous Services.* But the activities encompassed in the following reports—*Education Services; Health Services; Lending, Guaranteeing and Insuring Activities; The Post Office;* and, as mentioned, *Miscellaneous Services*—are sufficiently representative to disclose the variety of the means by which public wants are met

and the impact which federalism makes on the development of the services rendered by the Government of Canada.

MODES OF SERVICE

The classic form of service to the public is exemplified by the Post Office: enjoying a monopoly (excluding particular services such as parcel post, money orders and the savings bank), directed by a minister of the Crown and operated by civil servants within the general forms and rules governing the departments of government. But many alternative ways of satisfying public wants have been devised in recent decades, and the federal government can choose from a variety of modes of service.

This element of choice is evident in most of the following reports—for example, in the choice to be made between direct lending operations conducted through a country-wide administrative apparatus, or the pursuit of the same ends by offering appropriate guarantees or financial inducements to non-governmental institutions which already possess the necesary administrative machinery and are engaged in activities closely resembling or related to the services contemplated by the government. In some instances, the services in question are already provided by private undertakings, and the interest of the government lies essentially in reducing their cost to users, or facilitating their wider use, by the payment of subsidies to users or suppliers. In other cases again, where the federal and provincial governments have identical or complementary interests, services may be provided by joint action, with a pooling of funds and administrative machinery—and sometimes with the added participation of municipal or even non-governmental bodies, particularly in health and welfare services.

Each mode of service gives rise to different organizational and administrative needs within the federal government. In addition, of course, no two modes produce exactly the same results or give the same degree of satisfaction to the public. Consequently, the choice cannot rest solely—or even primarily, in most cases—on the administrative implications of the various courses of action available. But these administrative implications should not be ignored in the planning of government services.

The record of most advanced countries in recent decades shows a general tendency for the role of central governments in satisfying public wants to become increasingly comprehensive—embracing more and more aspects of the lives of more and more people—and, at the same time, increasingly indirect in its impact. The old and new patterns can be seen at various points in the following reports—within, for example, the operations of the National

Health Branch as described in the report on *Health Services.* On the one hand, this Branch provides direct service to a selected group, under the Indian and Northern Health Services, employing its own hospitals, clinics, medical staff, supply organization and all the accompanying overhead—with capital and current expenditures (in 1960-61) of $23 million. On the other hand, under the Hospital Insurance and Diagnostic Services programme, the National Health Branch contributed $189 million in 1960-61 toward the costs of hospital treatment for virtually the entire Canadian population, with an administrative effort that was but a fraction of that required for the Indian and Northern Health Services.

Direct provision of services by the federal government raises general questions concerning costs and the degree to which they should be recovered from the recipients of the services. Under existing methods of accounting, the true cost of operations is frequently obscured by the exclusion of capital and overhead items and supporting services supplied without charge by other agencies. In addition, the general practice of absorbing departmental revenues into the Consolidated Revenue Fund rather than applying them to meet associated costs tends to weaken administrative concern with the relationship between costs and revenues. Recommendations put forward by your Commissioners in the report on *Financial Management* would correct these weaknesses. There remains, however, a further need to establish uniform policies governing the recovery of costs from the recipients of services and defining when and to what extent services should be provided at less than cost. This need is encountered in a number of the following reports, and your Commissioners' general conclusions are set out in the report on *Miscellaneous Services.*

In addition to reducing the burden of administration imposed on the federal government, the less direct means of providing services may often provide a greater measure of flexibility in federal programmes. Programmes involving only the payment of grants and subsidies can be more readily modified or terminated at fairly short notice than can those for which special facilities and organizations have been created by the federal government. Grants and subsidies should not be varied capriciously, and changes must be planned and executed in a manner which permits necessary adjustments in the external machinery which will be affected—a need which appears to be inadequately recognized in some of the programmes examined. But the problem of modification or adaptation is unquestionably greater in federal organizations designed to provide a specific service directly to the public or to a particular group.

Moreover, there is a clear need to review services at frequent intervals in order to determine, in the light of changing conditions, whether the means being employed are the best available. The balance of factors favouring a particular course may change for many reasons. The public need may disappear, or so diminish as to render the original mode of service inappropriate—as, for example, in the treatment of tuberculosis among Indians. The development of more comprehensive services may eliminate or reduce the special needs of a particular group—for example, mariners or veterans. Or, the development of alternative services by other bodies—provincial and municipal governments or private agencies—may place more effective machinery within reach of the federal authorities. If federal programmes are to respond to changes such as these, the periodic review of services must look behind the mode to the intent. Only when this is done can the continuing need for a particular service, or for service rendered by a particular mode, be judged.

Some of the considerations entering into the choice of modes are not unlike those examined in relation to the "Make or Buy" question in Volume 2, "Supporting Services for Government". And, other things being equal, your Commissioners favour those modes which assign to other agencies the actual provision of a service to the public, leaving to the federal government the definition of goals and standards and the provision of financial support or other incentives. In this way, the day-to-day control of the service can be brought closer to the beneficiaries and made more responsive to their needs. At the same time, the operational burdens of the federal government can be minimized, leaving it free to concentrate on the tasks which only it can discharge. In addition, the growth of the public service can be checked, and the plurality of other institutions—public and private—serving the Canadian people can be strengthened, not only in the resources available to them but also in experience and skill.

Your Commissioners recognize that, in proposing greater devolution of the service function by the federal government, they are pre-supposing the existence of honest, competent and responsive organizations to which the administration of services may safely be entrusted. However, as the federal government becomes increasingly involved in the definition of economic and social goals and standards, no other assumption seems tenable. The alternative is a monolithic society in which services become more and more concentrated in the hands of the central government and all other organizations atrophy for lack of function or resource. Your Commissioners do not believe the latter course to be either desirable or necessary. Nor do they believe that

the tendency toward a more comprehensive role for government in the economic and social life of the country can be arrested; but as this process continues, the importance of the other organizations by which the public is served should be enhanced rather than diminished.

FEDERAL-PROVINCIAL CO-OPERATION IN JOINT AND ALLIED SERVICES

As the federal government has assumed new responsibilities it has become involved in a growing range of services which complement provincial activities or which, because of the constitutional division of powers, require provincial co-operation in their execution. Concurrently, the range of provincial services has shown a comparable growth, with the two-fold effect of, first, multiplying the points of intersecting interest and, second, bringing into existence new administrative resources, provincial and municipal, of increasing size, diversity and skill.

A review of the findings of the Royal Commission on Dominion-Provincial Relations, before World War II, discloses that the number and variety of intergovernmental contacts have grown phenomenally in recent decades. At least sixteen of the principal federal departments and almost as many other agencies now have some close and significant concern with matters in which provincial governments have common or related interests.

The machinery of provincial (and municipal) government lies, of course, wholly outside your Commissioners' terms of reference. However, in examining the organization and operations of the federal government in this growing range of matters in which federal and provincial governments have joint or allied interests, the development of provincial machinery cannot be ignored. The existence today of energetic and competent public services in the provinces enlarges the opportunities for administrative co-operation between the two senior echelons of government and requires a re-examination of many federal services to determine whether adequate account has been taken of provincial developments. In recognition of this, the Commission undertook a general review* of federal-provincial co-operation in joint and allied services. From this review there emerged a number of conclusions of general relevance to a wide range of federal services to the public.

It is important to recognize that the basic relationship between the federal and provincial governments cannot be one of principal and agent. Constitu-

*Under the direction of Eric Hardy, of Eric Hardy Consulting Services, Toronto, and Professor François-Albert Angers, L.SC.COMM., Ecole des Hautes Etudes Commerciales, Montreal, assisted by C. N. Rowse, B.A., B.ED., B.SC. (ECON.) M.A., Director of the Budget, Province of Manitoba, Winnipeg, Thomas J. Plunkett, M.A., Municipal Affairs Consultant, Montreal, and Jacques LaRivière, L.SC., POL., Montreal.

tionally, the two are of equal status, and each is accountable to its own electorate. Consequently, the relationship between them must be one of equality, based on mutual recognition of the authority and responsibility proper to each and mutual respect for each other's administrative competence.

Each fresh discovery of a convergence of federal and provincial interests in recent years has produced, with few exceptions, some degree of co-operation. Among the services of concern to your Commissioners, including a number of those discussed in the following reports, four general kinds or degrees of co-operation were identified:

- Consultation, leading to a concerting of plans and operations.
- Joint programmes in which costs and administrative responsibilities are apportioned.
- Delegation of functions by one government to another, by executive agreement.
- The contracting of services by one government from another.

Arrangements of these kinds, with variations and modifications, will be particularly evident in the ensuing reports on *Education Services* and *Health Services,* but many other programmes are similarly affected—in welfare, labour, services to agriculture, fisheries, forestry, and other resource industries, in housing, transportation and many other areas.

Consultation

No complete listing exists of the federal-provincial conferences and committees of more than a temporary nature dealing with intergovernmental relations. The composition of such a list would vary depending on whether particular bodies were classified as committees or sub-committees, but separate listing would be warranted for at least fifty. Most of these are of comparatively recent origin; the older ones, for the most part, have become increasingly active in recent years. In size, breadth of interest and degree of activity, they vary widely, each having evolved in response to a specific need and without the guidance of any general principles or plan. There is, for example, no general co-ordinating body in the welfare field comparable to the Dominion Council of Health, to which reference is made in the report on *Health Services.*

However, the formal machinery of federal-provincial committees and conferences represents only a part of the consultative process. Of equal—perhaps greater—importance is the continual consultation by telephone, correspondence and visits. Moreover, as patterns of intergovernmental co-

operation become established by the formal machinery, the need for frequent conferences should diminish. This was noted, for example, in the case of a federal-provincial conference which has been held annually for a number of years. The federal officer responsible for organizing the 1961 conference found it difficult to prepare an agenda until he hit upon the happy notion of a broad review of the whole field which had been covered intensively, in piece-meal fashion, at previous conferences. While there may be value in such retrospective sessions at rare intervals, regularity of conferences should not become a fetish when co-operative arrangements have been well established.

Consultation, of course, is only of value when it leads to a concerting of action. This may take a number of forms, some of which are noted in the report on *Public Information Services:* the pooling of efforts in the promotion of tourist travel and the distribution of federal public health material through provincial and local channels. Knowledge of each other's programmes and intentions—in research, for example, or the compilation of statistics—can eliminate wasteful duplication or divergence of effort. However, the most distinctive form of co-operation is the joint service in which costs and administrative functions are shared by the federal and provincial governments.

Conditional Grants

The initiative in developing cost-sharing programmes has come predominantly, although not exclusively, from the federal government. And almost invariably, federal participation is dependent upon provincial undertakings to administer the programmes in accordance with agreed conditions. The importance of such arrangements to both levels of government may be gauged from the fact that in 1961-62 the federal government provided over $500 million in conditional grants, a ten-fold increase from 1945.

Canada is by no means alone in this growing resort to conditional grants; similar arrangements have become increasingly prevalent in many countries. There have been criticisms in Canada and elsewhere that the grants tend to distort the budgets of recipient governments by creating rigidities and causing over-emphasis of grant-supported activities; and that they tend to undermine the federal system by forcing provincial governments to choose between accepting federal direction in matters of provincial jurisdiction or denying to provincial residents any share of federal funds derived, in part, from their own taxes. Defenders of the grants see nothing sinister or objectionable in them on principle; both the federal and provincial governments may have legitimate and reconcilable interests in a wide range of matters, and the

conditional grants provide a means of making common cause.

Your Commissioners do not take sides in this debate. But the prevalence of conditional grant programmes cannot be ignored in any study of federal administration. The kind of conditions attached to federal grants, and the actions taken by federal departments in ensuring that the conditions are met, are of relevance not only to the attitude of provincial recipients but also to the efficiency and economy of the federal government.

Examination of the current grants discloses striking variations in the conditions attaching to them and in the role of the federal authorities in the administration of the joint programmes. Moreover, it is abundantly clear that the differences among conditional grant programmes are the result more of historical accident than of any clear and consistent principles.

In many cases the variations in conditions follow logically from differences in the objects pursued. It is, for example, to be expected that the federal authorities should be more concerned with the quality of work performed on the Trans-Canada Highway than with the construction standards of provincial or municipal works receiving federal aid under the Winter Works programme. The federal object in the first case is to secure the construction of a transcontinental highway of defined standard; in the second it is concerned only with influencing the timing of construction activity.

Other variations in the field of construction, however, are less easily explained. The Department of Public Works, for example, has administrative responsibility for both the Trans-Canada Highway and Roads to Resources programmes. In both cases, it exercises an item-by-item control over payments to provinces within the limits of approved costs. In the Trans-Canada Highway programme, individual items may be overspent by as much as ten per cent without recourse to the Treasury Board for authority, provided the authorized total amount is not exceeded. In the Roads to Resources programme, on the other hand, no leeway is permitted on individual items without reference to the Treasury Board. Even greater contrast is provided by two conditional grant programmes administered by the Department of Northern Affairs and National Resources, for the construction of camp grounds and picnic areas along the Trans-Canada Highway, and as Winter Works. In both cases, control is exercised on a project rather than an item-by-item basis. The costs—and hence the grants—involved in highway construction programmes are, of course, much greater than those associated with camp grounds and picnic sites, but the practice of the Department of Northern Affairs at least raises questions about the degree to which itemized control is exercised by Public Works—over culverts, for example.

The procedures required by the federal government in the administration of grants for the support of blind and disabled persons provide another example of inexplicable variation. Both programmes are administered by the Department of National Health and Welfare, with the federal contribution to the blind persons' programme amounting to seventy-five per cent of the cost compared with fifty per cent under the disabled persons' scheme. Despite the similarity in aims, the two programmes employ totally different techniques for the medical review and approval of applications, the difference being incomprehensible either in terms of the variation in the federal share of costs or on any other basis. The one feature common to the two programmes is that the procedures for review of applications seem unnecessarily cumbersome.

Moreover, the haphazard differences in conditions and procedure are matched by variations in the stringency with which conditions are enforced. At one extreme, a rigid refusal by the federal government to contribute to the purchase of land for highway purposes can produce absurdities. For example, it may refuse to share in the purchase of a $15,000 farm whose intersection by a highway would cut off the barns and water supply from the pastures, but be willing to split the expense of a $50,000 underpass to keep the farm intact. A similar situation arises where the federal government refuses to share in the outright purchase of a building but will contribute toward the greater cost of relocating it.

Other examples can be cited of contrasting laxity in the enforcement of conditions. Several may be found in the administration of national health grants. With certain stated exceptions, the agreements provide that costs of administrative personnel employed by a provincial health department to implement the grant programme will not be shared; in fact, it is reported that a significant number of such persons are paid from health grant funds. Under the same programme, the regulations state that no more than eighty per cent of the amount allotted under each grant item can be committed annually for continuing services; but one province proposed, in 1962-63, to devote ninety-three per cent of the mental health grant to continuing services, and to apply federal funds for tuberculosis control on the same basis.

The existence of anomalies such as the foregoing points to a need for a comprehensive and continuing review of conditional grant programmes. This review can serve several objects: the introduction of order and consistency, based on clear and cogent principles, and the elimination of any unnecessary or distasteful burdens imposed on provincial and municipal authorities.

In addition, systematic attention should be given to the avoidance of processes of control and review which pointlessly duplicate provincial activity. In the administration of national health grants, for example, in many cases the use of federal medical consultants in evaluating projects duplicates work already done by provincial consultants. Progress has been made in recent years towards reduction of detailed federal auditing of provincial cost records and greater reliance on the effectiveness of provincial procedures. The federal government cannot, of course, divest itself of responsibility or escape its accountability to Parliament for the manner in which its funds are spent under conditional grant programmes, but greater acceptance of the adequacy of provincial control and review processes seems possible.

Administration Delegation and Contract Services

Executive action on the part of the federal and provincial governments has permitted the administrative machinery of one to be used for the purposes of the other in a variety of ways. These arrangements may take a very simple form—as, for example, in the appointment of certain federal Indian agents to serve additionally as provincial welfare officers. At the other extreme, one of the most highly developed co-operative arrangements can be seen in the regulation of fisheries, where certain federal regulations are not only administered by the provinces but are prepared by the federal government to meet provincial wishes. Or the machinery of one government may be employed, under contract, to serve the purposes of the other, the outstanding example being the employment of the Royal Canadian Mounted Police to provide provincial and local police services in eight provinces and more than sixty municipalities.

Of particular relevance to the present inquiry—and particularly to the reports on *Education Services* and *Health Services*—are those situations in which the federal government has assumed responsibilities towards specific groups for services normally considered to be provincial or local matters. In the view of your Commissioners, a clear distinction must be drawn between the responsibility for ensuring that such special needs are met and the actual rendering of the service. The first may be inescapably federal; the second, however, may more properly be entrusted to provincial and local authorities on mutually acceptable terms.

It is recognized that, in certain circumstances, the actual provision of such services must be undertaken by the federal government—because of the isolation of the group to be served, or because a special need of short or uncertain duration would require facilities and staffs out of all proportion

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to the other requirements of the community. But the findings of your Commissioners on education and health services suggest a need for more systematic attention to this question, not merely when federal services are initiated but at regular intervals thereafter, as the further development of provincial and local services may eliminate the justification for direct federal action.

The Need for Systematic Review

The observations in the foregoing pages should not be permitted to obscure the very significant development of federal-provincial co-operation in the past two decades. As the activities of both levels of government have grown in scale and diversity, there has been a general recognition of the need for co-operation and general avoidance of duplication in services. The lack of order and system in the arrangements developed may itself be viewed as reflecting the initiative and freedom to experiment, enjoyed—and exploited—by the federal departments.

There is, nonetheless, a clear need for a more systematic approach to federal-provincial co-operation, to identify areas in which development has lagged and stimulate corrective measures, to remove anomalies and, on the basis of the extensive experience of recent years, to evolve general principles to govern future initiatives by the federal departments. What is required, in the federal government, is a central organization concerned with all aspects of federal-provincial relations and assisting ministers in the development of policy and in the review of administrative arrangements for co-operation.

The nucleus of such a group already exists in the Department of Finance. But the Federal-Provincial Relations Division in this Department has been developed primarily as a permanent conference secretariat concerned in the main with financial aspects of intergovernmental relations. Given enlarged terms of reference and the necessary additional staff, this group could be developed to serve the needs which have been pointed out in the foregoing pages:

- To review federal-provincial consultative and co-operative arrangements generally.
- To stimulate federal initiatives in areas where existing arrangements appear inadequate.
- To formulate general principles for the removal of existing anomalies and to guide future federal initiatives.
- To advise departments and the Treasury Board on the possible use of provincial administrative machinery to meet federal needs.

In putting forward these proposals, your Commissioners make no evaluation of the various administrative relationships established between the federal and provincial governments. Because these arrangements frequently give rise to questions of public policy, any such evaluation clearly lies beyond your Commissioners' terms of reference—as does the question of the boundaries of federal and provincial jurisdiction as defined by constitutional enactments and judicial decisions.

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SERVICES FOR THE PUBLIC

REPORT 15: HEALTH SERVICES

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1

INTRODUCTION

The operation of hospitals and health services is basically a provincial responsibility, and the scale of provincial efforts in this field has been steadily expanding. The federal government has contributed support on an increasing scale, the total so expended in 1961-62 amounting to $317 million. Notwithstanding the quickening tempo of provincial activity, the federal government has for various reasons developed its own programmes, costing about $139 million in 1961-62.

While much activity is devoted to the health needs of particular classes of the population—veterans, Indians, Eskimos and servicemen—a significant proportion of these beneficiaries are now entitled as ordinary citizens to facilities under provincial jurisdiction. In the judgment of your Commissioners, the maintenance by the federal government of continually expanding machinery for health services, located almost entirely within the provinces, represents an example of duplication and waste from the national point of view. Continuation of present policies will necessitate very substantial federal expenditures for new facilities, and will compound the problems arising from unnecessary duplication.

Apart from treatment and hospitalization, some of the advisory and technical services now duplicate the efforts of the provinces. In health services, as in other areas noted in the reports of the Commission, many of the federal government's activities originated before the provinces had developed significant programmes of their own. As the level of provincial activity has mounted and direct responsibility has been assumed in provincial pro-

grammes, the federal government has shown a marked reluctance to withdraw from the field, and has tended to justify its continued participation by turning to research and relatively minor subsidiary operations.

In their very nature, parallel health and hospitalization programmes of the provinces and the federal government not only entail duplication and added costs, but serve to impede the development of a proper balance of facilities on a community basis. Your Commissioners believe that, in principle, these unfortunate results may be avoided only through the assumption by the provinces of the prime responsibility and the relegation of the federal government to the provision of necessary residual services.

THE HEALTH PROGRAMMES

This report deals with three major areas of federal activity: medical care and hospitalization of special groups, the promotion of public health, and programmes of a preventive nature. All three involve, to some degree, medical and allied research and investigation, and the compilation and analysis of health statistics.

Each of these is described briefly hereunder. The principal departments of the government engaged in providing health services are the Departments of National Health and Welfare, Veterans Affairs, and National Defence.

Medical Care and Hospitalization of Special Groups

The federal government is heavily involved in providing medical care to Indians, Eskimos, veterans, servicemen, members of the Royal Canadian Mounted Police, inmates of federal penitentiaries, seamen, lepers, and the white population of the Territories. Services to the Armed Forces personnel, veterans and native peoples account for all but a very small proportion of the total expenditures. All servicemen, veterans with service-incurred disabilities, veterans receiving War Veterans Allowances, and native people without means, receive medical care at the expense of the federal government. The majority receive hospital care in federal hospitals, but a significant number of each of these groups is treated in regular community facilities. To provide this care, the federal government employs over 19,000 persons, including 784 doctors and 2,800 nurses. Federal hospitals, with accommodation totalling approximately 12,300 beds, are operated in all provinces and territories except Prince Edward Island, and two facilities are maintained in West Germany. The estimated net total operating costs come to $115.5 million. The clientele for these services includes over 200,000 Indians, Eskimos and residents of the Territories; 130,000 servicemen and Royal Canadian Mounted Police personnel; and about 200,000 veterans. All told, over half a million

Canadians look to the federal government to provide or finance their medical care. Federal hospital facilities are roughly equivalent to those of the province of Alberta, which serve a population almost two and one-half times as large.

Promotion of Public Health

Two means are employed by the federal government to aid the provinces in discharging public health responsibilities: financial aid and advisory or technical services. These programmes are conducted by a relatively small but expert group of about 500 persons, all employed in the Department of National Health and Welfare.

The largest component of financial aid is the assistance rendered to all provinces under the *Hospital Insurance and Diagnostic Services Act* of 1957, which provides for the sharing of the costs of provincially operated hospital insurance programmes. Federal contributions now total $270 million annually and are fixed by formula.

The National Health Grant programme, initiated in 1948 and now providing about $50 million annually, is to assist the provinces to develop and extend health facilities. These grants help finance hospital construction, tuberculosis control, mental health, professional training, cancer control, public health research, medical rehabilitation, crippled children, and child and maternal health. In the main, the grants are made to hospitals and individuals on a shared-cost basis with the province.

In addition to these programmes, advisory and technical services are provided to the provinces and to federal agencies. The services include advice on the assessment of hospital facilities, the initiation of new programmes, and the raising of existing programmes to adequate standards. The units engaged in these services undertake, as well, specific research programmes.

Preventive Measures

There are three programmes which have as their purpose the prevention of disease, all carried out by various units of the Department of National Health and Welfare. The first is concerned with examining people, ships and aeroplanes to ensure that communicable diseases are not brought into the country; that immigrants meet proper health standards; and that civilian air personnel are in good physical condition. Some 350 medical staff are employed across Canada and in certain countries abroad.

The second programme, administered by the Food and Drug Directorate, is designed to control the safety, purity and quality of foods, drugs, cosmetics and therapeutic devices sold or manufactured in Canada. A staff of about 400 are engaged in this work throughout Canada.

Table 1—COSTS OF HEALTH PROGRAMMES[1]—1961-62—(Estimates—$ millions)

	Expenses			
	Operating	*Construction*	*Revenue*	*Net Cost $ millions*
Medical Care and Hospitalization to Specific Groups				
Veterans[2]	68.4	5.3	16.8	56.90
Indians, Eskimos and population of Territories	22.9	2.1	2.5	22.50
Servicemen[3]	37.0	—	1.2	35.80
Lepers, Seamen, Inmates of federal penitentiaries[4]	.8	—	.5	.30
SUB-TOTAL	129.1	7.4	21.0	115.50
Preventive Programmes				
Food and Drugs	2.6	—	—	2.60
Emergency Health	6.7	—	—	6.70
Quarantine and Immigration[5]	3.0	—	—	3.00
Civil Aviation Medicine	.2	—	—	.20
SUB-TOTAL	12.5	—	—	12.50
Promotion of Public Health				
Consultant and Advisory Services	3.7	—	—	3.70
Civil Service Health	.5	—	—	.50
SUB-TOTAL	4.2	—	—	4.20
Research				
Department of Veterans Affairs	—	—	—	.40
National Health Grants (National Health and Welfare)	—	—	—	5.70
Defence Research Board	—	—	—	1.60
Medical Research Council	—	—	—	3.30
The Queen Elizabeth Fund for research into diseases of children	—	—	—	.05
SUB-TOTAL	—	—	—	11.05
Other Health Costs				
Administration—Dept. National Health and Welfare (one-half of total)	—	—	—	.90
National Health Grants (Dept. National Health and Welfare) (less research grants)	—	—	—	24.30
Hospital Construction Grants (Dept. National Health and Welfare)	—	—	—	17.00
Contributions to provinces under Hospital Insurance and Diagnostic Services Act	—	—	—	270.00
Grants to Health Organizations (Dept. National Health and Welfare)	—	—	—	.20
SUB-TOTAL	—	—	—	312.40
GRAND TOTAL COST				455.65

[1]These figures are estimates, compiled from various sources by Commission staff. Precise figures, particularly in the case of the Armed Forces, are not available.
[2]Includes Prosthetics Services, salaries of medical personnel only for Canadian Pension Commission, and three-quarters of cost of D.V.A. Administration Branches.
[3]Dental Corps not included.
[4]Costs for services to lepers included with Quarantine and Immigration (costs very small).
Costs for staff salaries Sick Mariners' services included with Quarantine and Immigration. Salary costs only shown for services to inmates of federal penitentiaries.
[5]Includes also expenses for lepers and salary costs of Sick Mariners' services.

Table 2—FEDERAL PERSONNEL ENGAGED ON HEALTH PROGRAMMES[1]—1961-62

	Doctors	*Nurses*	*Others*	*Total*
Medical Care and Hospitalization to Specific Services[2]				
Veterans[3]	210	1,670	9,940	11,820
Indians, Eskimos plus population of Territories	110	630	1,830	2,570
Servicemen[4]	460	500	3,780	4,740
Inmates of federal penitentiaries	4	—	—	4
SUB-TOTAL	784	2,800	15,550	19,134
Promotion of Public Health				
Consultant and Advisory Services	30	—	406	436
Civil Service Health	6	50	26	82
SUB-TOTAL	36	50	432	518
Preventive Programme				
Food and Drugs	1	—	372	373
Emergency Health	4	—	38	42
Quarantine and Immigration[5]	107	60	169	336
Civil Aviation Medicine	5	—	12	17
SUB-TOTAL	117	60	591	768
Other[6]	—	—	175	175
TOTALS	937	2,910	16,748	20,595

[1]These figures represent authorized establishment, not actual strength—strengths are in most cases lower, particularly in the Canadian Forces Medical Services.

[2]Figures rounded.

[3]Includes doctors attached to Canadian Pension Commission (58), and three-quarters staff of Departmental and District Services Administration units.

[4]Dental Corps not included.

[5]Includes staff for services to lepers and seamen.

[6]One-half of Administration Branch staff, Department of National Health and Welfare.

The third programme is one of assisting provincial and municipal governments to organize, prepare and operate health facilities for use in national emergencies. This function is carried out by 42 members of the Emergency Health Services Division.

COSTS AND PERSONNEL

In Table 1 the costs of the various health programmes are shown, with a subdivision into operation and construction costs, grants and research funds The number and salary costs of staff are listed in Table 2.

2

MEDICAL CARE AND HOSPITALIZATION OF SPECIAL GROUPS

The special groups for whom the federal government assumes responsibility in health matters number more than half a million people. Their medical care is provided by the Departments of National Health and Welfare, Veterans Affairs, National Defence, and the Office of the Commissioner of Penitentiaries.

These health services must be viewed against the background of the recent substantial development of community health services. Until the post-war period, medical and hospital care in Canada was not well organized. Government controls and support were minimal and standards of medical care varied widely. Hospitals were hard put to balance their budgets; stability in operating income was not to come until the late 1950's, with the advent of the Hospital Insurance and Diagnostic Services Act, which provided for federal-provincial support for hospitalization.

In the face of a general shortage of hospital facilities in Canada in the post-war period, the federal government, enlarging from year to year its area of accepted responsibility, had no alternative but to undertake construction of hospitals on a large scale. Having built the necessary facilities, it has proceeded to operate them as federal institutions (*see* Table 3).

Most of the accommodation consists of active treatment beds, with all the diagnostic and ancillary services required for acute cases. The cost of this programme is not readily ascertainable, but the present replacement value of the federal hospitals is upward of $250 million.

Developments in the past ten years have substantially altered the picture. Under the stimulus of generous construction grants, community facilities have

Table 3—FEDERAL HOSPITALS—RATED BED CAPACITY, DECEMBER, 1961[1]

Hospital	*Location*	*December 1961 Rated Bed Capacity*
	Department of Veterans Affairs	
Camp Hill	Halifax, N.S.	410
Lancaster	Saint John, N.B.	400
Ste. Foy	Quebec City, P.Q.	325
Queen Mary	Montreal, P.Q.	700
Ste. Anne's	Ste. Anne de Bellevue, P.Q.	1,200
Sunnybrook	Toronto, Ont.	1,563
Westminster	London, Ont.	1,520
Deer Lodge	Winnipeg, Man.	640
Col. Belcher	Calgary, Alta.	400
Shaughnessy	Vancouver, B.C.	950
Veterans Hospital	Victoria, B.C.	300
Regina General[2]	Regina, Sask.	186
University of Alberta Hospital[2]	Edmonton, Alta.	318
TOTAL D.V.A. BEDS		8,912
	Department of National Health and Welfare, Indian and Northern Health Services	
Frobisher Bay	Frobisher, N.W.T.	13
Lady Willingdon	Oshweken, Ont.	36
Moose Factory	Moose Factory, Ont.	168
Sioux Lookout	Sioux Lookout, Ont.	72
Assiniboine[3]	Brandon, Man.	227
Clearwater Lake[3]	The Pas, Man.	155
Fisher River	Hodgson, Man.	15
Fort Alexander	Pine Falls, Man.	16
Norway House	Norway House, Man.	39
Fort Qu'Appelle	Ft. Qu'Appelle, Sask.	104
North Battleford	N. Battleford, Sask.	50
Blackfoot	Sleichen, Alberta	27
Blood	Cardston, Alberta	39
Charles Camsell	Edmonton, Alta.	480
Hobbema	Hobbema, Alta.	16
Inuvik	Inuvik, N.W.T.	100
Whitehorse	Whitehorse, Yukon Terr.	120
Coqualeetza	Sardis, B.C.	187
Miller Bay	Prince Rupert, B.C.	175
Nanaimo	Nanaimo, B.C.	200
TOTAL I.N.H.S. BEDS		2,234

Hospital	Location	December 1961 Rated Bed Capacity
Department of National Defence[4]		
R.C.A.F. Station	Goose Bay, Labrador	35
Can. Forces Hospital	Halifax, N.S.	150
R.C.N. Hospital	H.M.C.S. Cornwallis, N.S.	35
Can. Forces Hospital	Rockcliffe, Ont.	125
Can. Forces Hospital	Ottawa, Ont.	320
Can. Forces Hospital	Kingston, Ont.	125
Ft. Churchill Hospital	Ft. Churchill, Man.	70
R.C.A.F. Station	Cold Lake, Alta.	50
R.C.N. Hospital Naden	Esquimalt, B.C.	100
Canadian Section, B.M.H. Iserloka	West Germany	125
R.C.A.F. Hospital 3 Fighter Wing	West Germany	70
TOTAL D.N.D. BEDS		1,205
TOTAL ALL DEPARTMENTS		12,351

[1]Infirmaries on military bases and in penitentiaries are excluded. Table completed by Commission staff, and based on departmental returns.

[2]The beds specified are in veterans pavilions which, although attached to and dependent upon public hospitals for certain services and facilities, are owned and largely staffed by the Department of Veterans Affairs.

[3]These institutions are operated by the Sanitarium Board of Manitoba for the Indian and Northern Health Service. The Assiniboine Hospital is soon to be transferred to Manitoba.

[4]In addition to the hospitals specified under the Department of National Defence, it operates and staffs wards for military personnel in three D.V.A. hospitals. The number of D.N.D. beds (which are included in the total shown for each hospital) are 77 in Ste. Foy, 83 in Sunnybrook, and 43 in Westminster Hospital.

been greatly enlarged through the provision of additional hospital beds. The jointly financed hospital insurance plans have all but cured the deficit operations of community hospitals, and the standard of care has risen appreciably and become more consistent across the land. Most significantly, the great bulk of the population has gained access to hospital service as a matter of right and at a very modest personal cost.

WAR VETERANS

The Canadian Expeditionary Force in the first World War suffered heavy casualties. It became apparent that existing hospital accommodation in Canada was insufficient to care for the seriously wounded through their period of recovery. To meet this need, federal hospitals were established in various parts

of Canada. The expectation that they would be needed for a limited period was reflected in the conversion of some old buildings to hospital purposes and the building of new semi-permanent structures. This hope proved illusory, and at the outbreak of World War II many of these facilities, by then seriously inadequate, were still in active use.

It was expected that the casualties of World War II would be substantially more than in the earlier conflict. Fortunately, in spite of a heavier enlistment, this assumption proved false. However, a programme of new hospital construction was undertaken on a large scale, and since the end of the war the older hospitals have been either replaced or largely rebuilt. Currently there are eleven veterans' hospitals, with a total capacity of 8,408 beds. There are, in addition, veterans' pavilions attached to two general hospitals, two health and occupational centres with 385 beds, and two homes accommodating 135 veterans.

The standards of medical care in these hospitals have been high. The hospitals have always operated between the wars with local practitioners serving on a part-time basis for modest fees. With the expanded programme resulting from World War II, the major element of professional care is still supplied, again on a part-time basis, by leading members of the medical profession. The affiliation of many of these hospitals with local medical schools and their consequent involvement in teaching and research guaranteed a standard of care equal to that in the best of the hospitals in the country. However, for reasons mentioned later, this situation is not likely to endure.

Supplementing the present attending and consulting staffs in veterans' hospitals are 165 employed doctors, 35 dentists and 1,650 nurses. These, together with administrative and service personnel totalling 8,600, are civil servants.

The annual cost of operating the veterans' hospital programme is approximately $50 million. This does not include charges to votes of other departments or indirect costs, but it does include the cost of care of certain veterans who enter public hospitals because access to a federal hospital is not readily available.

The original aim was to provide for the grievously wounded. Treatment facilities in the expanded programme resulting from World War II were designed for the care only of veterans with pensionable disabilities. Today, however, the class of patient and the nature of the malady of the typical case in hospital are radically different. No less than seventy per cent of the case load now consists of chronic cases or those in need of no more than domiciliary care. Under existing policies this percentage will progressively

increase. In the main, chronic and domiciliary care is being provided to veterans whose fighting days ended in 1918 or earlier. The veterans of World War II and Korea, in substantially greater numbers, have still to come. Without any further liberalization in the conditions of entitlement, and assuming a recurrence of past patterns, it is estimated by officers of the Department of Veterans Affairs that the case load will double, with the peak to be reached in 1980 (*see* Table 4). Thereafter numbers will decline

Table 4—PROJECTION OF MALE VETERAN POPULATION FROM 1951-1981 AND VETERANS ENTITLED TO TREATMENT UNDER VETERANS TREATMENT REGULATIONS FROM 1961-1981.

Year	*Disability Pensioners*[1]	*Veteran Recipients*[2]	*Veterans Living*
		(thousands)	
1951	162	31	1,170
1956	160	37	1,117
1961	153	49	1,051
1966	137	46	970
1971	118	47	876
1976	97	55	770
1981	77	79	656

[1]Entitled to treatment for service incurred disabilities.
[2]Entitled to medical care and hospitalization.

Table 5—EXPENDITURE FOR HOSPITAL CONSTRUCTION, YEARS ENDING MARCH 31, 1951-1961, AND PROJECTED EXPENDITURES TO 1968.

Year	*Expenditure*	*Year*	*Expenditure*
1951 (Actual)	$3,008,426.00	1960 (Actual)	$3,742,116.00
1952 (Actual)	3,267,190.00	1961 (Actual)	5,407,272.00
1953 (Actual)	3,550,182.00	1962 (Forecast)	4,670,000.00
1954 (Actual)	3,552,837.00	1963 (Estimated)	3,800,000.00
1955 (Actual)	3,265,330.00	1964 (Projected)	4,180,000.00
1956 (Actual)	3,094,780.00	1965 (Projected)	5,300,000.00
1957 (Actual)	3,989,162.00	1966 (Projected)	4,600,000.00
1958 (Actual)	2,642,769.00	1967 (Projected)	4,200,000.00
1959 (Actual)	2,703,597.00	1968 (Projected)	1,400,000.00

NOTE: The projected expenditures for fiscal years 1963-1968 include 14 million dollars for construction of improved facilities at Montreal, Ste. Anne de Bellevue and Saskatoon. The construction planned for these locations will replace obsolete and inadequate facilities but does not represent any increase in total accommodation.

rapidly and demand will disappear in a few years. The veterans' hospitals, containing upward of 16,000 active treatment beds (unless present policies are changed), will then become surplus to government requirements.

The capital outlays ahead are formidable sums to contemplate: 8,500 new beds at present costs of $23,000 each will require a minimum expenditure of nearly $200 million (*see* Table 5). Operating budgets may be expected to more than double in view of the steadily rising costs of hospital operation. Expenditures of this magnitude to provide active treatment beds to house chronic and homeless veterans appear unwise from every standpoint. The cost of providing suitable accommodation and care in properly designed domiciliary institutions represents fifty per cent or less of the capital investment required, and a smaller percentage of the operating costs of active treatment hospitals.

Further consequences of the change in the nature of the patient population of these hospitals have serious implications both for operating costs and the quality of medical care available. As the case load changes, the difficult and challenging problems resulting from combat disabilities give way to the routine chores of caring for a group of elderly males suffering from chronic illness, senility or general decrepitude. Such cases have limited medical interest and little value for teaching purposes. The probability is that, progressively, medical care will have to be provided by fully-employed doctors. If so, costs will rise materially and the standard of care is bound to decline. As matters now stand, the prospect is that by 1980:

- An additional $200 million will have been spent to double the present bed capacity.
- The operating budget will have risen to over $100 million annually.
- The hospitals will be almost wholly occupied by patients requiring only domiciliary care.
- The quality of medical care will have fallen from the high standards originally achieved.

Reference has been made to the original intent that these hospitals should serve the war veteran who returned to Canada with service-incurred disabilities. Today this group represents but ten per cent of the patient population and the proportion continues to decline. Over the years the doors have been thrown open to a wide range of non-service disability cases, and some members of other groups for whom the government assumes direct responsibility have been admitted to keep up hospital occupancy. The average case

load in these hospitals today subdivides broadly into the three following categories:

Veterans with service disabilities (but not necessarily being treated for such disability)	10%
Veterans admitted as pay or part-pay patients; sick and injured members of the Armed Forces and the R.C.M.P.; Indians, Eskimos, sick mariners, etc.	25%
Veterans in receipt of war veterans' allowances (low income veterans)	65%
	100%

Currently, the majority are World War I veterans who are in hospital for reasons other than war disabilities. The *Department of Veterans Affairs Act* permits the Governor in Council to define the persons who may be admitted to the hospitals and, as beds available progressively out-numbered the requirements for war disability cases, Orders in Council have broadened eligibility for admittance and free treatment. It is not inappropriate to regard the situation as out of balance. Since 1957-58, provincial hospitalization insurance plans (supported by federal contributions) have offered protection to all Canadians whenever the need for hospitalization arises. Where domiciliary care, as in this instance, is the primary need, it is generally agreed that it is a costly misapplication of facilities to provide such care for extended periods of time in acute-care hospital beds.

As the problem of care for the old without adequate means has developed in respect of veterans, so has it been increasingly accepted as a community responsibility for the population at large. Prompted finally by the need to exclude such persons from active treatment community hospitals in order to accommodate the seriously ill, and assisted by the increases in old age pensions, there has been a growing programme of facilities for domiciliary care of the indigent. Federal policy must take note of this trend and, from every point of view, the avoidance of further duplication of facilities is to be desired. The interests of the federal government and the communities coalesce at another point—in the existence of over 6,000 active beds in federal hospitals not occupied by acute cases while, in most communities, there is still a substantial shortage of such accommodation.

Should accommodation in the federal hospitals again be restricted to veterans with pensionable disabilities, one of the larger existing hospitals could

theoretically accommodate them all. For geographical reasons, such a solution is impracticable. However, patients in this category are already being accommodated in public hospitals at federal expense and such practice might be advantageously extended, with a view to bringing about a reasonable consolidation of federal hospital activities, which would make much needed acute facilities available to communities.

The more immediate problem is, of course, the chronic and domiciliary care class, both present and future. The extent of federal responsibility is a question of policy; your Commissioners are concerned only with the means adopted to carry out policy. It is difficult to imagine a more costly solution than that embodied in present practice. Your Commissioners' first conclusion is that there should be no further construction of active treatment hospitals. To the extent that federal responsibilities dictate new construction, it should be of the domiciliary institution type. In view of the limited period in which these facilities will be required by veterans, they should be either of temporary construction or designed for adaptation to general community needs.

Of these alternatives, the latter appears to your Commissioners to be preferable. The *British North America Act* assigns to the provinces "the establishment, maintenance, and management of hospitals, asylums, charities, and eleemosynary institutions in and for the province, other than marine hospitals." Experience built up in this type of care has largely been achieved as a result of the work of the Department of Veterans Affairs. It would seem logical for the Department of Veterans Affairs to undertake further study in the field of domiciliary care facilities. The total load of patients required would not be great and they could be selected from the original group covered—the pensionable veteran. To the degree that there is federal responsibility for the aging and indigent veteran, it would seem more appropriate that the government contribute towards construction of the appropriate facilities by local authority or the provinces, rather than undertake further construction itself to meet a transient need.

The policy envisaged is a gradual integration of federal and community facilities and the eventual withdrawal by the federal government from the operation of veterans' hospitals, hostels or homes. There is no doubt that hospital care in provincially supervised institutions has reached an adequate level for any treatment needs of those veterans with service-incurred disabilities —a class for which the federal government must have the most direct concern. Moreover, in the process of integration, the transfer of federal facilities can be made on terms that assure priority of admission for this group.

Because of the varying conditions in communities where federal hospitals are situated, the problem will have to be approached city by city. An opportu-

nity for integration now exists in Victoria, B.C., where the Armed Forces have immediate need of 100 to 125 active beds. There is a veterans' hospital in the city with 300 such beds, at present occupied to the extent of eighty per cent by chronic or domiciliary care cases. An effective solution which would avoid construction of a new Armed Forces active hospital is to be found by turning over the veterans' hospital to the community, reserving the necessary accommodation for Armed Forces personnel on a priority basis, and erecting a suitable institution to provide, under community management, domiciliary care for the displaced veterans and possibly others. The gains to all would be substantial.

We therefore recommend that:

1. No further hospitals be constructed by the government as active treatment hospitals for war veterans.
2. Progressively, the treatment of veterans with pensionable disabilities be transferred to public hospitals, with the cost borne by the federal government.
3. Veterans with major pensionable disabilities, who require chronic or domiciliary care, continue to be a federal responsibility.
4. Veterans without major pensionable disabilities now receiving chronic and domiciliary care at public expense be progressively transferred to community facilities under such financial arrangements as may be expedient.
5. Active treatment hospitals now operated by the Department of Veterans Affairs, when cleared, be sold and converted into community hospitals under transfer agreements providing preferential admission rights for veterans with pensionable disabilities.

INDIANS AND ESKIMOS

The Indian and Northern Health Services of the Department of National Health and Welfare are responsible for medical and public health services for most of the 185,000 Indian and 11,500 Eskimo residents of Canada. Within

the limitations of resources and available working conditions, the Services attempt to bring to this population facilities available to the general public through private physicians, municipal public health units, and public hospitals.

The extent and nature of the responsibility of the federal government to provide free health services for Indians in populated areas of the country is not clearly defined. Neither the *Indian Act* nor other statutes refer specifically to native health services, and the established arrangement owes its existence solely to annual appropriations by Parliament. At least one Indian Treaty requires that the Government of Canada maintain medicine chests at the homes of Indian Agents, and that these be used at the discretion of the Agents. In practice, however, any Indian or Eskimo living on a reserve or Crown lands can today obtain medical and hospital care at little or no personal expense.

Initially, health care was given by Army physicians and missionaries. In 1908 a few public health nurses were employed by the Department of Indian Affairs, an arrangement which marked the beginning of the present Indian Health Services. An organized medical service was founded in 1928 and expanded slowly during the next nine years. By 1937, tuberculosis had virtually reached epidemic proportions among the Indian population. The annual death rate from this disease alone was 2,000 per 100,000 population, and at this point federal government activity was stepped up. In 1945, the Medical Service was removed from the Indian Affairs Branch to the Department of National Health and Welfare and, in 1954, the responsibility for Northern Health Services was added. The growth has continued, and a budget of less than $1 million in 1937 increased to $23 million in 1960-61.

The Indian and Northern Health Services are now charged with the responsibility for providing hospital services to Indians and all residents of the Territories. The hospital services fall naturally into three groups:

- Hospital services for Indians within the provinces, which are provided in various ways. In several parts of Canada, Indians are hospitalized in community hospitals where they are, for the most part, freely accepted. In other areas, hospitals owned, operated and staffed by the Indian and Northern Health Services provide care exclusively for Indians; the majority are located in regions where community hospitals capable of caring for Indians already exist.
- Hospital services available to the general public in areas where community services do not exist. The Northern Health programme is intended to provide, in the Yukon and Northwest Territories, the same services as a provincial health department.

- Hospitals operated as referral centres for the native populations. These hospitals, all within the provinces, of which the Charles Camsell in Edmonton is the best and largest, serve as:

  a. Referral centres for problem cases in the Indian and Eskimo populations.

  b. General hospitals for Indians in the immediate vicinity.

  c. Holding units for native patients who, while recovered from acute conditions, are not yet ready to return to a rigorous environment.

Medical and dental care is provided to all Indians within the provinces and to Indians, Eskimos and other residents of the Territories. Although the native population expect this service to be free, an attempt is made to collect moderate fees from those financially able to pay.

The Indian and Northern Health Services, with 2,568 authorized personnel, operate eighteen hospitals* with a total rated capacity of 1,882 beds, approximately evenly divided between tuberculosis and general treatment. In addition, many small medical treatment units, nursing centres, and public health units are operated.

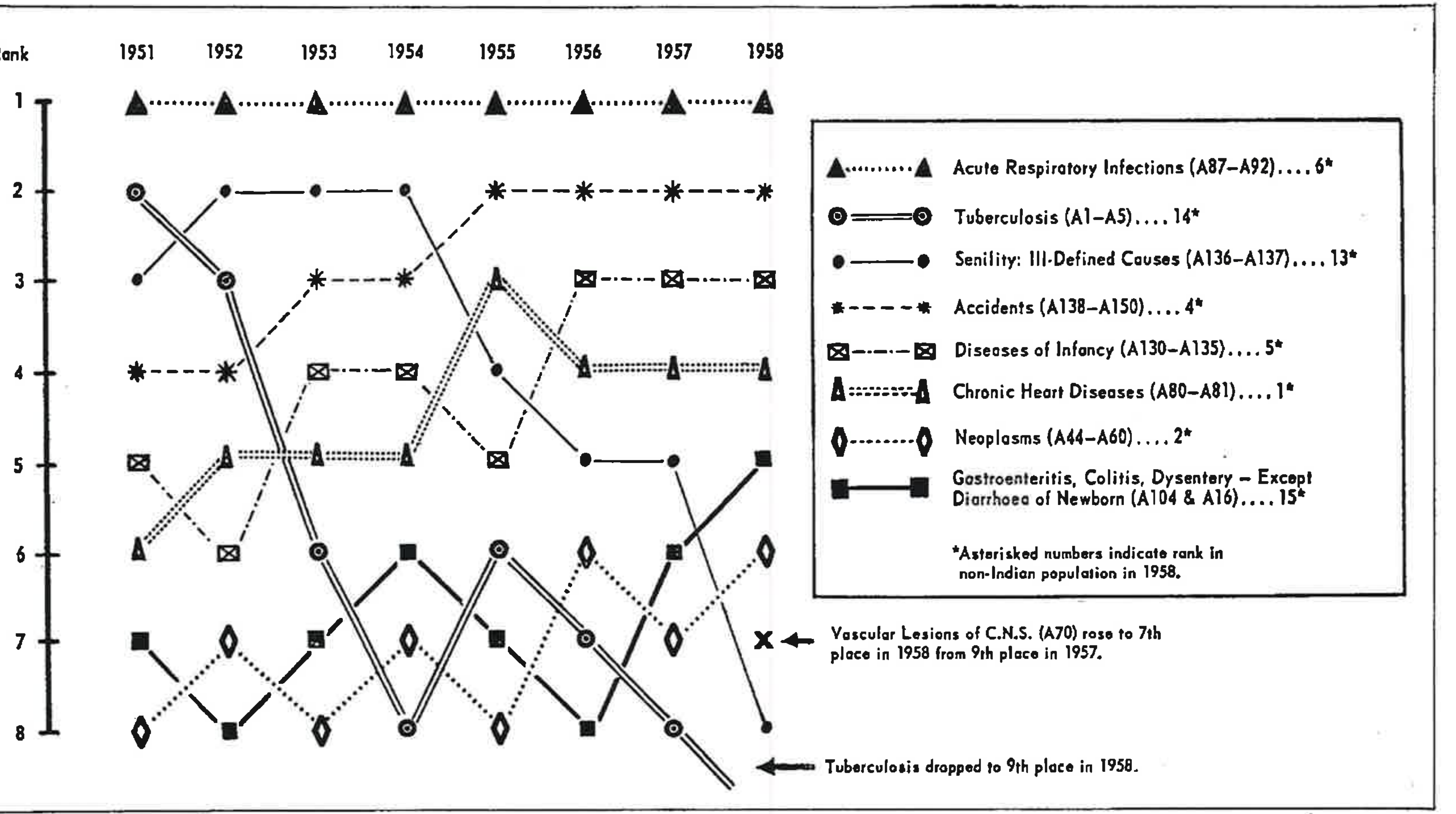
Too frequently, the quality of care in Indian and Northern Health Services hospitals is not comparable with that provided in community hospitals in the same area. The hospital facilities are generally old, ill equipped and inadequately staffed; moreover, it is evident that the Department finds it hard to get suitable personnel, particularly in the lower ranks.

Of the 117 physicians who have joined the Department of National Health and Welfare in the past five years, forty-seven per cent are graduates of foreign medical schools. Many of them have not passed their Canadian licensing examinations and are therefore not qualified for private practice. The Canadian physicians joining the service in the same period averaged 40 years of age. The great majority of these had left private practice. The Department always has unfilled posts, and few young Canadian graduates show any interest because of the remoteness of places of employment, the ill equipped hospitals, and limited opportunities for career development.

There is no evidence that the very significant number of Indians who depend for health services on ordinary community facilities are receiving care inferior to that supplied by Indian and Northern Health Services facilities. The intro-

*The Assiniboine Hospital at Brandon (227 beds) and the Clearwater Lake Hospital at The Pas (155 beds) are operated for the Indian and Northern Health Service by the Sanatorium Board of Manitoba. The transfer of ownership of the former to Manitoba is now being negotiated.

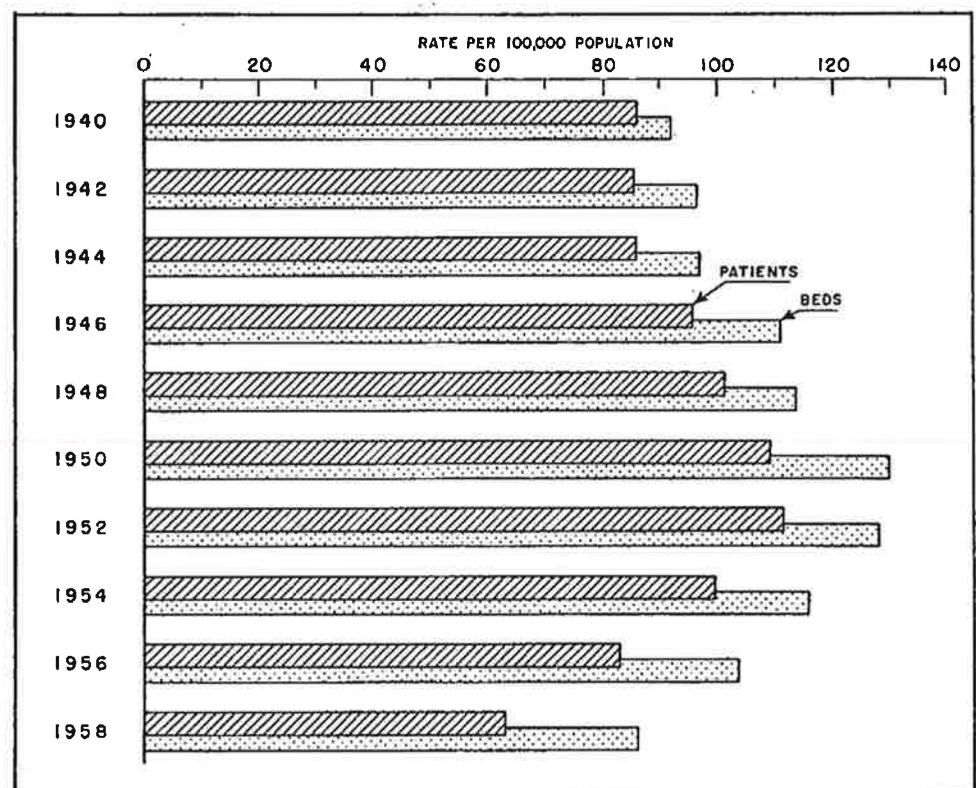
Chart 1—SELECTED CAUSES OF INDIAN MORTALITY BY RANK, 1951-1958*



* Annual Report, Department of National Health and Welfare, 1960.

duction of government supported hospitalization for all citizens also provides native people with easy access to hospitals. The cost of pre-paid insurance premiums, even when borne by the federal government, is an economical means of providing hospital care. Similarly, the existence of many pre-paid insurance plans for physicians' services makes medical care relatively simple for either the Indian himself or the government to arrange.

Chart 2—PATIENTS IN TUBERCULOSIS SANATORIA AND BED CAPACITY*



* Canada Year Book 1960.

Tuberculosis has long been a major cause of illness and death to the native people, and many of the present-day services arose from the need to combat this disease. However, since 1937, the annual death rate from tuberculosis has been reduced from 2,000 per 100,000 population to 40 per 100,000, and from 1951 to 1958, tuberculosis, as a cause of Indian mortality, fell from second to ninth rank (*see* Charts 1 and 2). Compared to the 1959 death rate of 5.5 per 100,000 persons in the general population, the disease is still serious but, as a problem peculiar to native people, it is no longer of critical significance.

The integration of Indians with the general population is being vigorously promoted by the Indian Affairs Branch of the Department of Citizenship and Immigration, particularly in the education of Indian children. In health services the possibilities of successful integration have been amply demonstrated in several parts of Canada. In fact, in some of the provinces separate facilities for Indians have never existed. The conclusion is unavoidable that, from the standpoint of convenience and expense, as well as the quality of care, the use by Indians of established community facilities is highly to be desired.

The express policy of the Department of National Health and Welfare is to turn over the responsibility for medical care for Indians to the provinces, but progress is slow and more positive promotion of the policy is required. The declining tuberculosis rate makes it probable that all Indian cases could be looked after in provincial sanatoria within a very few years. Obviously, some time will elapse before hospital services in unorganized remote areas can be assumed by the community, but immediate steps should be taken to end the duplication of facilities in the more populous areas of the provinces.

The hospitals used as referral centres (for example, Charles Camsell in Alberta, and Coqualeetza in British Columbia) present a more difficult problem. The excellent work of the Charles Camsell hospital with native patients has earned for it an enviable reputation. Its existence, serving only Indian and Eskimo patients, has made the prospect of hospitalization reasonably acceptable to shy Indian and Eskimo patients who might have been less responsive to treatment, particularly long-term tuberculosis treatment, in a setting where they were in the minority among white patients. Nonetheless, the need for this segregation is passing. Indians in southern Alberta are treated in an integrated tuberculosis sanatorium, and no serious problems have been encountered.

There are strong indications of diminishing need for these hospitals. The Camsell hospital's 480 beds were well filled until two years ago, but in 1960 the hospital had only a seventy-five per cent occupancy. At the Coqualeetza hospital occupancy is falling and the length of stay increasing—an indication of lack of pressure for beds. These hospitals are expensive to operate. As a result of the difficulty of attracting interns and residents, work normally assigned to such staff is done by more expensive full-time medical staff. At the Camsell hospital, the high quality of professional care results principally from the strong university affiliation. Senior members of the teaching staff at the University Hospital in Edmonton act as consultants and manage problem cases. This has been achieved although the two hospitals are several miles apart.

The Department does not, regrettably, plan to relinquish these referral hospitals. In fact, an immediate rebuilding of the Camsell hospital on its present site is planned, at a cost of over seven million dollars, and a further building programme for Coqualeetza is in prospect. Your Commissioners were not convinced by the arguments in support of these plans. Cases of tuberculosis now make up two-thirds of the patients at the Camsell hospital. The majority of these could be cared for in empty beds in sanatoria in the provinces. The tuberculosis cases from the Territories could be treated either in local hospitals or brought to sanatoria in adjacent provinces.

Excluding tuberculosis cases, the present patient load on Camsell is about 120 patients. These could be cared for in the University Hospital, Edmonton, or other hospitals in the region. Should it be deemed essential to continue some segregation of Indians and Eskimos for a further period, it would be desirable to consider building an addition to the University Hospital in Edmonton of, say, 100 beds. This would provide professional medical care by the staff of the University Hospital on a more satisfactory basis than at present. It would mean that many of the present fifteen full-time staff members could be replaced by interns and residents at a lesser cost. Apart, however, from the monetary savings and the standard of care, the building of a large new segregated hospital for natives is inconsistent with the policy of integration actively pursued by the Indian Affairs Branch of the Department of Citizenship and Immigration, and somewhat less enthusiastically subscribed to by the Department of National Health and Welfare. In health matters, the progress toward full integration, already less rapid than desirable, is bound to be affected for many years by a large new investment in segregated hospital facilities.

Much of the very real progress which has been made in reducing disease in the native population has been due to the educational efforts of public health nurses. This aspect of the service should not be curtailed in any circumstances. However, there is evidence that such nursing service within the provinces could be taken over by provincial nurses. In many instances, provincial nursing staffs are located in towns near reserves and could provide care to Indians more economically than under the present arrangements. This would not be true in the Territories and remote areas, where a strengthening of the special service is justified.

We therefore recommend that: 1 A positive programme be developed for the more rapid transfer of Indian health care to normal community facilities in populated areas of the provinces.

2 Where possible, medical and dental care be arranged through private practicing physicians and dentists (with the federal government bearing the cost of pre-paid medical plans where necessary).

3 The referral hospitals, Charles Camsell at Edmonton, and Coqualeetza at Sardis, B.C., be neither rebuilt nor extended.

SERVICEMEN

Before 1958 each of the Armed Services had its own medical branch. In that year orders were issued to integrate the three medical services into a single Canadian Forces Medical Services. This group comprises over 4,700 personnel and its cost, excluding capital construction, is estimated at over $35 million in 1962-63. Apart from a large number of "sick bays" or infirmaries, eleven hospitals with a total capacity of 1,205 beds are operated. Certain problems have delayed the completion of the integration programme. More detailed comment on these difficulties is contained in the report on *The Department of National Defence*.

In the field of medical care, the Armed Forces have certain obvious requirements that must be met from their own resources. Aside from succouring the wounded in time of war, provision must be made for personnel in barracks, afloat, or located in isolated areas. In general, the existing system of infirmaries and sick quarters must continue to be staffed and maintained for such purposes, and the Armed Forces must carry on their strength qualified doctors, nurses, and other specially trained personnel.

The needs of the Armed Forces within Canada in peacetime, however, do not necessitate the operation of special acute treatment hospitals of their own. The character of war, with its present nuclear hazard, invalidates the concept of yesterday under which the creation of hospital capacity for war wounded might have appeared a farsighted precaution. An argument may be advanced that the ability of Service doctors to practise in their own hospitals is necessary to the achievement of a suitable degree of professional competence, as well as for a desirable effect upon *esprit de corps* generally. While this contention may have some validity, your Commissioners see no compelling reason why Service personnel who are in need of hospitalization in peacetime should not be treated in community facilities.

At present, a number of acute treatment hospitals are operated by the Services for the use of military personnel in areas that already have well

developed community hospital facilities. As previously mentioned, consideration is currently being given to the construction of new Service hospital facilities in Victoria, B.C.

Under provincial hospitalization insurance plans, Service personnel are entitled to hospitalization in whichever province they are located, and, in the view of your Commissioners, community facilities should be employed in preference to the creation of segregated institutions. This view is reached not only from considerations of cost and quality of medical care, but in the belief that the establishment of a system of Service hospitals across Canada constitutes an unnecessary elaboration of the responsibilities of the Armed Forces, which affords no significant advantages.

We therefore recommend that:

1 The hospital care of Service personnel in Canada be gradually transferred to civilian hospitals, and no building of new Service hospitals or replacement or enlargement of existing institutions be undertaken.

2 Vigilance be exercised to prevent the expansion of sick quarters and infirmaries into more sophisticated treatment centres in areas where community hospitals exist.

3 The Canadian Forces Medical Services be allocated 100-125 beds in the Department of Veterans Affairs Hospital, Victoria, pending complete integration of Service and community needs, and the Royal Canadian Navy Hospital, Naden, be abandoned.

While it is apparent that the training of specialists in the Armed Forces in recognized clinical fields of medicine is satisfactory, there is evidence that insufficient emphasis is being given to aero-medicine. In the Royal Canadian Navy there is a need for increased knowledge of the effects of underwater environment. The Services might well give greater attention to the medical aspects of abnormal environments, which are becoming increasingly significant. A number of medical officers sufficient to manage the resultant problems must receive the necessary training.

A subsidy programme to encourage medical students to enter the Armed Services has been in effect for several years. The present programme finances

them through four years (three years of medical school and one year of internship). A married student can obtain a total of $16,386 in a period of 45 months, in return for which he must give three years of service at the rank of army captain. This subsidy programme is undoubtedly generous but might be more productive if aid were given for four years of medical school and not for the internship year, when at least some funds are available from other sources. Moreover, because this programme starts only in the second year of medical school, its existence is often known only to individuals who have already entered medicine and have presumably already arranged for the financing of their education. If the subsidy were offered from the first year, students would be attracted to medicine who, for financial reasons, would not otherwise be able to embark on a medical education.

Ancillary medical personnel in the Armed Forces have been receiving training in their respective trades in schools run separately by each Service. Only minor progress has been made in bringing them together for training. Integrated training programmes should be immediately adopted for all ancillary medical personnel.

It has been noted that the three Services have different physical standards for recruitment examinations. Physical standards must be different for individuals in special categories, (e.g. aircrew require higher physical standards), but trades common to the three Services should certainly have common standards. Such a policy is essential to satisfactory operation of the tri-service recruiting units.

OTHER GROUPS

Inmates of Federal Penitentiaries

Five federal penitentiaries have a total "maximum security" capacity for 4,365 inmates. All penitentiaries have facilities with less rigorous security policies, which provide additional capacity for almost as many prisoners. There is a hospital unit in each penitentiary, which usually consists of offices for physicians, clinic rooms for sick parades, and special cells. In the main they are adequate but, in the Kingston Penitentiary, the thirty-five-bed hospital built in 1850 and still in use was condemned in 1938 by the Royal Commission on the Penal System in Canada.

The Director of Medical Services for Penitentiaries, based in Ottawa, travels extensively and represents the sole medical link with the penitentiaries. With few exceptions, the professional medical staff employed at the penitentiaries is part-time, and includes phychiatrists. Psychologists in the penitentiaries are not attached to the medical group but work with the classification department in attempting to evaluate the status of prisoners.

In most cases of acute illness, only medical ailments are cared for in the penitentiary hospitals. Surgical cases are referred either to the nearest Veterans hospital or to general hospitals in the community. This is expensive, for a guard must remain with the prisoner at all times.

Medical work in the penitentiaries contains a large element of psychosomatic or psychiatric medicine. Many of the prisoners require psychiatric care, but existing treatment practice is designed mainly to permit the prisoner to be treated as an inmate without creating undue problems for the penitentiary. At present, little or no attempt is made to prepare the prisoner for a more healthy approach to life after release.

Provision of more intensive psychiatric services to the inmates of federal penitentiaries is a complex problem. Prisoners are usually graduates of provincial gaols or, in many instances, of youth correctional centres, and it would seem more appropriate to apply curative psychiatric services in these earlier stages. However, there is one important psychiatric facility found in certain communities such as Toronto and Montreal which is sorely missed in others where it is not available. This is a forensic clinic whose function is to advise the court. Where such clinics operate, they usually owe their existence to the joint effort of a university and the Department of Justice. Problem cases before the courts are studied intensively for periods of ten days to a month, and correctional programmes are based on results of the studies.

The use of part-time medical professional personnel in the penitentiaries seems justified. The problems encountered in such institutions are highly specialized and, in the main, restricted. Full-time physicians would be neither content nor productive in such an environment.

Seamen

Part 5 of the *Canada Shipping Act*, which antedates Confederation, was designed to provide medical, surgical and hospital benefits for crews of foreign ships. Over the years, these benefits have been extended to other groups: first, to foreign fishermen arriving in Canadian ports; then to the crews of Canadian vessels which touch foreign ports; and finally to Canadian fishermen. In return for a very small charge, based on the ship's tonnage, the local Customs Office certifies that the crew of a particular vessel is entitled to these benefits. Services are provided by the Quarantine, Immigration Medical and Sick Mariners Services of the Department of National Health and Welfare in departmental clinics and in community hospitals at federal expense.

The Act applies only to the east and west coasts of Canada and to Hudson Bay, extending inland as far as Montreal in the east, and to coastal ports

only of British Columbia in the west. The extension of the St. Lawrence Seaway into Ontario renders this arrangement somewhat illogical.

There is evidence of extensive abuse of the Act, particularly by Canadian fishermen and tug-boat operators who, because the names of the crew are not required to be listed, can secure benefits for persons other than their crews with minimum risk of detection.

The cost of the service is currently about $800,000 a year, and receipts from tonnage levies meet less than half of this amount (*see* Table 6). For Canadian fishermen, whose relatively small craft produce only a nominal contribution, the amount paid out is twenty-five times that collected.

Table 6—HEALTH SERVICES FOR SEAMEN[1]—REVENUE, EXPENDITURE AND DEFICIT CLASSIFIED ACCORDING TO TYPE OF VESSEL

Calendar Year 1960

Classification of Vessel	*Revenue*	*Expenditure*	*Deficit*	*Deficit Expressed as Percentage of Revenue*
	$	$	$	
Foreign-going	460,065.27	509,052.64	48,987.37	10
Coasting	4,522.32	8,828.10	4,305.78	95
Fishing	14,374.56	314,399.80	300,025.24	2,087
Additional expenditure not classified as to type of vessel:—	—	14,544.91	14,544.91	—
TOTAL	478,962.15	846,825.45	367,863.30	76
Government (not paying S.M. Dues) Treatment provided under Authority of P.C. 1955-4/483 T.B. 484135 up to July 31, 1960[2]	—	45,870.85	—	—

[1]Annual Report, Department of National Health and Welfare, 1961—Sick Mariners Services.

[2]On July 31st, 1960, Order-in-Council P.C. 1955-4/483, which provided free treatment to crew members of government vessels, in the same manner as for crews of ships which pay dues, was repealed and treatment arrangements became the responsibility of the employing department. As a result, the total expenditure for the year was reduced to $45,870.85 from $86,221.07, the previous year. There were 2,076 eligible crew members employed on 200 government vessels.

With the recent extension of the Seaway, which may bring about an expansion of the service, and having in mind the fact that government-supported hospitalization is now available to all Canadians, it is considered by your Commissioners that this service should be discontinued.

We therefore recommend that: Part 5 of the *Canada Shipping Act* be repealed.

The Population of the Territories

It is not to be expected that adequate medical services for residents of the Territories can be provided as a result of community initiative, and federal initiative in building hospitals will be required for many years. The new hospitals at White Horse and Inuvik, opened within the past eighteen months, represent an improvement in facilities that have been on the whole less than adequate. Plans for improving the hospitals in the District of Mackenzie should be implemented as soon as possible. As communities develop, it will obviously be desirable to transfer the operation of federal hospitals to local authority as soon as possible.

The hospital at Fort Churchill, Manitoba, now operated by the Department of National Defence but serving a part of the Territories, is inadequate in size and poorly designed. Much of the patient load comes from the Indian population, and the provision of adequate water supply and sewage disposal would do much to improve the general health situation. A new hospital should be built, preferably under the auspices of the provincial government, with such federal government financial assistance as may be appropriate.

3

PROMOTION OF PUBLIC HEALTH

All the programmes falling into this category are administered by the Department of National Health and Welfare. Section 5 of the *Department of National Health and Welfare Act* assigns to the Minister a general responsibility "... relating to the promotion and preservation of the health, social security, and social welfare of the people of Canada over which the Parliament of Canada has jurisdiction ...", and then proceeds to define particular responsibilities. However, since its enactment in 1919, the federal statute has recognized provincial rights and declares: "Nothing in this Act or in any regulations made hereunder authorizes the Minister or any officer of the Department to exercise any jurisdiction or control over any provincial or municipal board of health or other health authority operating under the laws of any province."

There are two Deputy Ministers of National Health and Welfare responsible severally for the Health Branch and Welfare Branch, and jointly for seven administrative and technical divisions which provide common services to both branches. In 1961-62 the authorized staff was 5,300; 3,900 of these allocated to the Health Branch, 1,030 to the Welfare Branch, and 370 to the central administrative and technical divisions.

Until the fall of 1961, the Health Branch was composed of four services or directorates whose heads reported to the Deputy Minister of National Health and Welfare (Health). These were: Health Services; Indian and Northern Health Services; Medical Advisory, Diagnostic and Treatment Services; and the Food and Drug Directorate. The second and third of these are now being amalgamated in one Medical Services organization.

HEALTH SERVICES DIRECTORATE

This Directorate has four hundred and ninety-three classified positions, of which all except thirty-six in the Public Health Engineering Division are located in Ottawa. With thirty-four physician positions, the Health Services Directorate is responsible for administering environmental health programmes, national health grants, health insurance, international responsibilities in the field of health, and research development. There are fourteen consultant and specialist divisions, nine of which are quite small and primarily advisory in nature. These units are the Chief Nursing Consultant, and the Divisions of Child and Maternal Health, Hospital Design, Medical Rehabilitation, Mental Health, Dental Health, Blindness Control, Epidemiology, and Nutrition. The other five divisions are: Occupational Health, Radiation Protection, Public Health Engineering, the Laboratory of Hygiene, and Emergency Health. One special health programme, administered by the Medical Services Directorate, exists to meet the needs of the government's own employees. Your Commissioners' report on *Personnel Management* examines the Civil Service Health Division in some detail. In this report, comment is confined to those parts of the organization described above in which problems have been encountered.

NATIONAL HEALTH GRANTS

The National Health Grants Division co-ordinates the development of the health grant policies, the assessment of applications and the processing of payments. Almost $48 million was disbursed under nine grants in the fiscal year 1960-61. The health grant programme has been productive, but the detail required from recipient institutions and the provincial governments is excessive. These should be jointly reviewed and simplified. Consideration should also be given to placing the programme on a firmer basis in order to permit more long-term planning.

We therefore recommend that: The present reporting and accounting requirements for health grants be reviewed and simplified, and consideration be given to placing health grant programmes on a period-of-years basis.

ENVIRONMENTAL HEALTH

There are three programmes of environmental health: radiation protection, occupational health, and public health engineering. Each is carried out by a

separate division. A Principal Medical Officer is the senior staff adviser to the Director of Health Services on the three programmes.

The Occupational Health Division has grown rapidly. Its expansion was stimulated by the development of Crown corporations, whose occupational health has been regarded as a responsibility of the federal government; in all other industrial activities, occupational health is the responsibility of the provinces. The Division also provides consultant and technical assistance to government and industry, and carries out research. A central laboratory, employing fifty people, performs three main functions: it studies toxic substances encountered in industrial plants in Canada, samples air for toxic material, and does research work on the properties of substances whose effects on humans are not yet known. The work is closely related to radiation protection and public health engineering.

The Radiation Protection Division, with an authorized staff of sixty-one, fulfills similar functions in the field of radiation hazard; under a United Nations agreement, it also measures the radioactivity of rain and soil samples from several foreign countries.

The Public Health Engineering Division is, in many respects, unique among the components of the Health Services Directorate. Its primary functions are not directed to assisting the provinces, and most of its activities fall into two main categories: the administration of certain statutes and regulations, and the provision of technical advice to other components of the federal government. The chief regulatory activities of the Division are:

- The regulation of sanitary conditions and medical services for persons employed in the construction of federal public works.
- The regulation of sanitary conditions on railroad properties and ships of Canadian registry, with particular regard to the health of employees and passengers.
- The sanitary regulation of water and ice supplies on common carriers.
- The enforcement of regulations made by the International Joint Commission on boundary waters, "so far as the same relate to public Health".
- The enforcement of regulations on the sanitation and toxicity of shell-fish, in collaboration with the Laboratory of Hygiene and the Department of Fisheries.
- The inspection and analysis of water supplies for fish-packing plants, in collaboration with the Department of Fisheries.

This Division estimates that half its staff resources are expended on these inspection and regulatory functions. The remaining resources are occupied in providing public health engineering studies, advice, and designs, principally to other components of the federal government but occasionally to the smaller provinces.

The need for the regulatory functions of this Division, although at one time extremely important, seems now to have largely disappeared. Provincial departments have developed their own public health engineering groups. Federal employees in separate offices are superfluous in provinces where well-established departments are already in operation. For example, milk and water for common carriers, checked by provincial health departments, are rechecked by this Division. Most provincial departments of health have expressed a readiness to take over this function.

The need for many of the services of the three environmental health Divisions will continue to diminish as provincial and territorial departments become more complete, and constant vigilance will be required to ensure that the laboratories and other facilities necessary to provide these services do not continue to grow and take on other functions. There is a natural tendency for active, well-staffed laboratories to increase research activities as their service functions decline. Therefore, to control their growth, independent expert scrutiny of the research undertaken is necessary.

In summary, the three Divisions of Occupational Health, Radiation Protection and Public Health Engineering, all of which perform similar functions and provide services to the provinces, would function more effectively as a single Division of Environmental Health. In all three Divisions, the primary function should be to provide consultation and services to the provinces and territories.

We therefore recommend that:

1. The three Divisions of Occupational Health, Radiation Protection, and Public Health Engineering be combined into a single Division of Environmental Health.
2. Regulatory functions be left to the provinces to the maximum practicable extent.

REHABILITATION PROGRAMMES

The Blindness Control Division does excellent work with a small staff. It rules on eligibility for Blind Persons Allowances and operates a treatment

plan for those receiving allowances. The organization could be simplified and made more effective if the Division were absorbed into the Medical Rehabilitation Division, of which it is essentially a part.

The Medical Rehabilitation Division is a consulting unit in the field of medical rehabilitation, and carries on evaluation of disability under the *Disabled Persons Act*. In the former role, it assesses applications for payments under the Medical Rehabilitation Grant. The Department of Labour is charged with the co-ordination at the federal level of a comprehensive civil rehabilitation programme, but provincial co-ordinators are generally in provincial departments of health or welfare rather than labour departments. As rehabilitation is essentially a health problem up to the stage of vocational training, it would simplify administrative relations with the provinces if the Medical Rehabilitation Division were assigned responsibility for all medical aspects of the programme.

We therefore recommend that: All aspects of the medical rehabilitation programme be co-ordinated by the Department of National Health and Welfare.

OTHER ADVISORY AND CONSULTATIVE SERVICES

The functions of the Laboratory of Hygiene fall into three categories:

- Biochemical and biological research on human diseases.
- Technical services: National Reference Centre for certain groups of bacteria; production and distribution of standard solutions and diagnostic reagents; evalution of hospital laboratory techniques.
- Quality control of biological drugs in accordance with the *Food and Drugs Act* and Regulations.

The Laboratory of Hygiene is organized in seven Sections—Bacteriological, Biologics Control, Biochemical Research, Clinical, Zoonosis, Virus, and Administration. This laboratory shows signs of continued growth although provincial departments of health are developing increasingly effective laboratories. An indication of this trend is the development of significant programmes of a pure research nature in certain sections of the Laboratory. Several activities, particularly the analysis of biological drugs and the inspection of manufacturing facilities, would be more appropriately carried out by the Food and Drug Directorate.

The Nutrition Division has grown extensively in recent years, and performs a number of functions:

- Surveys on nutritional health of specific groups.
- Operation of a specialized nutritional assay laboratory service for physicians and provincial departments of health.
- Production of recipes for quantity cooking (e.g. for hospitals) in an experimental kitchen.
- Provision of educational material and consultant services to the provinces and territories.

These services have limited value to those who are expected to benefit from them. Little new information seems to have emanated from the food surveys in recent years. Provincial departments have developed their own nutritionists who are capable of performing surveys suited to the special needs of their own population groups. The nutritional laboratory enjoys scant usage by the medical profession; only about seven specimens are received monthly from practising physicians. The main source of material to the laboratory is provided by the departmental food surveys. The recipes developed for hospitals appear to be little used. There are other sources for such recipes and, in the provinces in which inquiries were made, no group was found that utilized these recipes.

The educational material produced by the Division is of value and should be continued. Consideration should be given to producing more nutritional material for native populations.

Consideration should be given to withdrawing the consultant services to provinces. Consultant and advisory services could be utilized to some degree in the Territories. Generally, there seems little need for the present strength, and consideration should be given to eliminating this Division and placing the remaining functions in another division, perhaps the Maternal and Child Health Division.

We therefore recommend that: 1 The programme of the Nutrition Division be carefully re-examined with a view to discontinuing unnecessary services and reducing staff.

2 The continuing responsibilities of the Division be assigned to the Maternal and Child Health Division.

The Hospital Design Division reviews plans for new hospital construction and since 1948, when federal grants became available, has scrutinized the planning for 83,000 patient beds. The staff is small and little effort has been applied to the development of special skills in the design of efficient hospital lay-out. There is undoubted advantage in developing an expert group in Canada to promote better hospital design, particularly as those responsible for building new hospitals frequently lack the specialized experience needed to achieve a functionally efficient structure of so complex a nature. How such a service can be best provided is a matter for mutual agreement between the governments concerned, but your Commissioners believe that unless the present Division can be converted into a useful agent for such purposes, which would require its substantial enlargement, it should be discontinued.

We therefore recommend that: The Hospital Design Division be either expanded to provide effective leadership in all phases of hospital design, or discontinued.

Your Commissioners were generally impressed by the manner in which the several divisions in the Health Services Directorate perform their functions, but certain inherent dangers merit discussion.

However knowledgeable a division head may be in his own field of medicine, there is a danger that, on ceasing active practice, he will find it difficult to keep abreast of new developments. The use of part-time consultants might offset any such deficiency, but it is difficult to attract outstanding individuals to this type of work.

In the few divisions in which they have been developed, advisory committees from outside the public service have been most effective in this regard. Relatively small advisory committees, chosen from leading professionals in the field, should be established for every division, meeting periodically with the division heads to promote new concepts and developments.

Further, because of the relative ease of securing continuing funds for programmes previously approved, there is always a possibility that programmes will continue after outliving their usefulness. The advisory committees should have the task of appraising and evaluating the work of their respective divisions.

We therefore recommend that: Each division in the Health Services Directorate have a small committee of outstanding non-departmental advisers, meeting regularly to:

a. Maintain and expand the knowledge of the division.

b. Evaluate current programmes, with particular reference to the continuing need therefor.

Finally, two further organizational changes are suggested for the Health Services Directorate. An Associate Director should be appointed, primarily to share the Director's extended span of control and to assist in appraising the programmes of the consultant divisions. An Assistant Director, National Health Grants and Hospital Insurance, is required in view of the importance of these activities. His duties should be the promotion of programmes and policies advocated by the Directorate, and co-ordination of certain aspects of existing programmes on behalf of the Director.

HOSPITAL PROGRAMMES

The past few years have witnessed the development of an important collaboration between federal and provincial governments, not only in respect to public health generally, but through jointly financed programmes for hospital construction and the operation of broad schemes making hospital treatment generally available to the public.

Involved in these matters is the Dominion Council of Health, the main function of which is to provide, at deputy minister level, liaison between the federal Health Branch and the provincial health departments. The Council comprises the Deputy Minister of National Health, as Chairman, the chief executive officers of the provincial health departments, a scientific adviser, and representatives of labour, agriculture, and urban and rural women's groups. The Council is an effective instrument for the exchange of views on federal health activities, particularly those of the Health Services Directorate which most directly affect the provinces, and in achieving co-ordination of provincial health programmes. It is to be noted that the Council, by reason of its constitution, is primarily concerned with ways and means, while matters of broad policy remain to be dealt with by representatives of the federal and provincial governments of cabinet rank.

The federal-provincial partnership in financing both construction of hospitals and their continuing operation is based on a sharing of cost which varies from province to province. The federal government's share in 1961 amounted to $287 million. The initiative in determining the kind of construction and the classes of operating services to be supported with public money rests largely with the provinces. If, therefore, a province chooses to support a certain service, the federal government will follow, but if a province refuses

to pay a share of a particular class of operation, the service in question is not available as part of the hospitalization scheme in that province.

One result is a variation between provinces in the payment for diagnostic costs on an out-patient basis. Provinces that refuse to cover such costs in their schemes do so on grounds of economy but they may, as a result, incur equal or greater costs, both capital and operating in nature, through the pressure for hospital beds caused by patients who unnecessarily enter hospital to obtain free diagnosis. It may, in this context, be significant that your Commissioners are credibly informed that Canadians are currently using hospital beds to a degree fifty per cent greater than in the United States and at about four times the rate prevailing in the United Kingdom.

The second matter of material financial consequence to the federal government, which falls within the discretion of the provinces under the agreements, relates to the type of new hospital accommodation being constructed. In the absence of any uniform planning approach, your Commissioners regard the present arrangements as being wasteful of public money. They encourage the continuing practice of building acute-treatment hospital beds to mediocre standards, rather than the selective building of beds to meet specific purposes —chronic and domiciliary care, general treatment; teaching and research.

Constitutionally, hospitals are a provincial responsibility, but it is difficult to believe that as a contributor of half the moneys expended the federal government is not entitled, simply on the grounds of getting its money's worth, to insist on more effective planning to avoid the waste arising from the present situation.

Proper planning in this field involves not only the avoidance of duplication of expensive facilities but the provision of hospital and patient-care facilities at various levels of cost and completeness of service, so that the people of Canada have access to the appropriate facility for each type of case. In Canada, at present, there is heavy spending for the building of acute-treatment hospitals, more on the basis of local pride and initiative than on the planned development of particular areas as a whole. Thus, open-heart surgery, a most costly activity, is being projected for virtually every large acute-treatment general hospital. There is no real need for such duplication of facilities, nor are there sufficient trained physicians to operate them.

The jurisdictional difficulties involved in resolving these problems and the federal role therein must be a matter of public policy, which is beyond terms of reference of your Commissioners. Comment is therefore restricted to the observation that the degree of waste is substantial, and to achieve a solution there is a clear need for the development of vigorous leadership, as well as co-operation.

4

PREVENTIVE PROGRAMMES

The preventive programmes are all undertaken in the Department of National Health and Welfare. Civil aviation medicine and quarantine and immigration medical services are responsibilities of the Medical Services Directorate. All aspects of the food and drug programmes are administered by the Food and Drug Directorate, and the planning for health services in time of national emergency is performed by the Emergency Health Services Division of the Health Services Directorate. The organization for the administration of these programmes seems basically sound. All told, some 770 persons are employed and the annual expenditure is about $12.3 million.

CIVIL AVIATION MEDICINE

The Civil Aviation Medicine Division was established by Order in Council in 1946 to "provide medical advice and assistance in setting out physical standards for civil aviation personnel" and "to advise on all matters connected with the health of travellers by air". The Division recommends physical standards to the Department of Transport for pilots and air traffic controllers, and also participates in the administration of these standards.

Civil air personnel, who are subject to licensing by the Department of Transport, must be periodically examined at their expense by private physicians who are appointed for the purpose by the Department of Transport. These reports are then reviewed by one of six regional medical officers employed by the Civil Aviation Medicine Division, who in turn advises regional

licensing authorities of the Department of Transport on the medical condition of the applicants. Any difficult case is referred to the Chief of the Division for his assessment before the Department of Transport is advised. All medical reports are finally filed in Ottawa where they are available to both the Civil Aviation Medicine Division and to the Department of Transport. It would be logical to assign complete responsibility to the Minister of National Health and Welfare for the medical examinations of civil air personnel, including the appointment of the private examining physicians.

Significant problems have arisen in the operations of this Division. For nearly two years there has been serious conflict over the visual standards set by the Civil Aviation Medicine Division and its consultants. Although originally accepted by the Department of Transport, some older pilots were unable to meet these standards, and they have not been enforced.

QUARANTINE AND IMMIGRATION

Quarantine, Immigration Medical and Sick Mariners Services (already reviewed) are administered in one division of the Medical Services Directorate. The Division employs about 336 persons in Ottawa, fifteen field offices in Canada, and several cities in Great Britain and Europe. The services of private physicians are extensively used on a fee-for-service basis both in Canada and overseas.

Quarantine

The Division administers the entire *Quarantine Act*, the purpose of which is to reduce the hazard of major communicable diseases entering Canada, by immunization procedures, by disposing of potential disease carriers and, when preventive measures fail, by detecting, isolating and treating diseased persons and contacts. This function is fulfilled by permanent and part-time personnel located at Canadian ports of entry.

At major airports a nurse or technician is on duty twenty-four hours a day, and a physician for arrival of foreign flights, for visual examination of passengers and the verification of immunization documents. At ports, large passenger liners are met by physicians, and other ships are dealt with by technicians. Ships are regularly inspected for rats by technical personnel, and fumigation is supervised by a physician. In unorganized and small ports, the quarantine work is done by customs officials.

The Quarantine Service, although very necessary in the past, could now be modified and reduced. Visual examination of passengers alighting from aircrafts or ships does not today result in the discovery of significant disease.

Although the Quarantine Service is responsible for preventing the entry into Canada of individuals suffering from any of the usual communicable diseases, the major fear is smallpox. The main defence against this disease lies in ensuring that vaccination has been performed.

In these circumstances, the attendance of present staffs at airports on twenty-four hour duty is no longer necessary. Customs or immigration officials could be given the task of examining immunization documents. For aircraft and ship arrivals from foreign countries, the attendance of a technician or nurse is sufficient.

Apart from the actual examination of sick passengers, technicians have performed all of the duties of the Quarantine Service. It seems logical to extend the use of their services.

We therefore recommend that:

1. Visual examinations of passengers arriving by aircraft and ship be discontinued.
2. Customs or Immigration officials be given the responsibility for examining immunization documents.
3. Technicians be employed in larger numbers to replace physicians and nurses in quarantine work not requiring professional skills.
4. A nurse or technician meet incoming aircraft and ships from foreign lands; and a physician be only on call for emergency situations.

Immigration

All persons seeking to enter Canada, other than temporary visitors and returning Canadian residents, are subject to medical examination. A general medical examination, including chest x-ray, is made on all immigrants. Non-immigrants (tourists, businessmen, etc.), are inspected and may be medically examined when necessary. Non-immigrant students are given a complete medical examination. Casual visitors from the United States are treated in the same manner as Canadian residents.

Medical screening overseas is carried out in three distinct ways. The majority of persons from Great Britain, Western Europe and Hong Kong are examined by physicians of the Department, who are stationed in the large cities. Where a lapse of several months occurs between examination of

the immigrant and his departure for Canada, he may again be examined or treated by departmental personnel at Canadian ports.

Physicians of the Department of National Health and Welfare are augmented by 'roster' doctors who do a small number of examinations in Great Britain and other European countries. These are local physicians who have been designated to make medical examinations of applicants for entry into Canada. Their reports and x-rays are checked by the Canadian Medical Officer supervising that area, who arranges for additional diagnostic work as indicated, advises the Department of Citizenship and Immigration regarding prohibited persons, and gives his opinion on a migrant's capacity to work at his occupation or on his suitability as an immigrant.

Neither Canadian physicians nor roster doctors are located either in communist countries or in countries from which there are few immigrants. Inhabitants of such countries seeking to enter Canada are examined at their own expense by physicians whose medical reports and x-rays are examined by a Preliminary Screening Section in Ottawa. If a visa is granted, the immigrant is subjected to a thorough physical examination and x-ray on arrival at a Canadian port. Examinations by Canadian physicians are free; others are not.

Treatment is provided for those who are ill on arrival and for all persons subject to Immigration jurisdiction after arrival. It is also provided for persons receiving subsistence from the Immigration Branch of the Department of Citizenship and Immigration and for immigrants who become ill in transit, if they lack resources.

There is evidence that the number of Canadian government physicians abroad is excessive. The number of examinations carried out in 1960-61 was 94,020. It is estimated that one doctor can examine 6,000 prospective immigrants in a year. In 1960-61, there were 46 doctors abroad, giving an average of 2,043 examinations per doctor (*see* Table 7).

Table 7—TOTAL EXAMINATIONS AND RE-EXAMINATIONS BY CANADIAN MEDICAL OFFICERS[1]—(EXCLUDING ALL ROSTER WORK)

Fiscal Year	*Examinations and re-examinations*	*Cost*	*Cost per Examination*
1958/59	104,543	$1,099,979	$10.52
1959/60	107,046	1,040,991	9.72
1960/61	94,020	1,165,600	12.39

[1]Department of National Health and Welfare figures.

Table 7—TOTAL EXAMINATIONS AND RE-EXAMINATIONS BY CANADIAN MEDICAL OFFICERS[1]—(EXCLUDING ALL ROSTER WORK)—(Continued)

Place	No. of Doctors	Total No. of Examinations	Performance Average No. of Exams per Doctor	Total Cost	Unit Cost: Cost per Examination	Capital Items
				$		$
BELFAST						
1958-59	1	1,521	1,521	27,440.00	18.04	—
1959-60	1	1,653	1,653	19,570.00	12.00	136.00
1960-61	1	1,210	1,210	31,476.00	26.00	5,370.00 (new office and X-ray)
BRISTOL						
1958-59	1	1,338	1,338	37,295.00	27.87	12,868.00 (X-ray plant installed)
1959-60	1	1,351	1,351	17,453.00	13.00	120.15
1960-61	1	1,074	1,074	13,770.00	13.0	—
GLASGOW						
1958-59	4/3	5,273	1,465	77,263.00	14.66	—
1959-60	3	6,826	2,275	69,269.00	10.00	798.00
1960-61	3	4,678	1,559	72,454.00	15.00	8,698.00 (new X-ray)
LEEDS						
1958-59	3/2	2,499	1,250	43,799.00	17.53	—
1959-60	2	3,043	1,523	34,313.00	11.00	25.00
1960-61	2	2,170	1,085	35,347.00	16.00	46.00
LIVERPOOL						
1958-59	3	3,667	1,223	53,699.00	14.65	76.00
1959-60	3	3,429	1,143	48,452.00	14.00	175.00
1960-61	3/2	2,414	—	44,505.00	18.00	50.00
LONDON						
1958-59	15*	12,504	1,250	322,249.00*	25.75	932.00
1959-60	15*	12,306	1,231	312,186.00*	25.40	2,935.00
1960-61	15*	10,095	1,010	391,624.00*	38.80	2,204.00
	*includes 5 administration or specialist consultants					
DUBLIN						
1958-59	—	965	—	5,617.00	5.82	Roster doctor, costs now doubled
1959-60	—	992	—	7,973.00	8.00	
1960-61	—	663	—	5,536.00	9.00	
THE HAGUE						
1958-59	4	7,313	1,828	60,373.00	8.00	523.00
1959-60	4	8,507	2,129	57,034.00	7.00	25.00
1960-61	4 (now 3)	4,289	1,072	61,134.00	14.00	—

Table 7—TOTAL EXAMINATIONS AND RE-EXAMINATIONS BY CANADIAN MEDICAL OFFICERS[1]—(EXCLUDING ALL ROSTER WORK)—(Concluded)

Place	No. of Doctors	Total No. of Examinations	Performance Average No. of Exams per Doctor	Total Cost	Unit Cost: Cost per Examination	Capital Items
				$		$
COLOGNE						
1958-59	6/5	8,613	1,723	79,269.00	9.00	—
1959-60	4	8,163	2,040	80,895.00	10.00	—
1960-61	4	6,207	1,551	90,815.00	15.00	—
BERLIN						
1958-59	1	2,346	2,346	13,236.00	6.00	—
1959-60	1	2,074	2,074	14,516.00	7.00	8,170.00
1960-61	1	1,592	1,592	15,447.00	10.00	555.94
HAMBURG						
1958-59	1	3,686	3,686	25,002.00	7.00	—
1959-60	1	3,244	3,244	18,856.00	6.00	—
1960-61	1	2,936	2,936	11,387.00	4.00	—
MUNICH						
1958-59	1	1,974	1,974	15,213.00	8.00	—
1959-60	1	2,572	2,572	15,837.00	6.00	—
1960-61	1	1,763	1,763	15,514.00	9.00	—
STUTTGART						
1958-59	1	3,795	3,795	14,984.00	4.00	—
1959-60	1	3,524	3,524	15,838.00	4.00	—
1960-61	1	3,238	3,238	17,826.00	5.50	—
ROME						
1958-59	6	39,799	6,633	112,546.88	2.80	—
1959-60	6	29,460	4,910	122,400.37	4.15	—
1960-61	6	24,837	4,156	147,199.00	5.92	2,302.36 (Air Conditioning)
ATHENS						
1958-59	1	6,373	6,373	17,692.00	2.78	
1959-60	1	6,207	6,207	27,245.00	4.39	720.00 (New Office)
1960-61	1	6,362	6,362	23,577.00	3.71	653.00
PARIS						
1958-59	3	4,102	1,367	59,335.00	14.00	—
1959-60	3	5,413	1,804	71,204.00	13.00	10,086.00
1960-61	3	5,685	1,895	73,786.00	13.00	862.00

[1]Department of National Health and Welfare figures.

Five of the doctors employed in London do not conduct examinations, and a few doctors elsewhere do not examine full-time. Nonetheless, it is clear the average workload for 1960-61 was less than one-half of the normal. The variation by location was extreme. The physician in Athens examined 6,362 persons, while his counterpart in London examined 1,010. The workload in London has not varied significantly for the last three years, yet no reduction has been made in the number of physicians. There are ten examining physicians operating at one-sixth of the normal workload, but no move has been made to reduce costs. The average cost per examination in 1960-61 was $12.39, varying from $3.71 in Athens to $38.80 in London. It is clear that, in those centres where more than one Canadian physician is now employed, staff reductions should be made immediately.

Even at full-employment, this type of work is routine, monotonous and confined within narrow limits, and deterioration of skill inevitably results. The employment of competent physicians full-time in this work is wasteful, particularly in view of readily available alternatives.

Fast-changing world health conditions allow a reappraisal of the methods of the Immigration Medical Service. General standards of health have improved in all parts of the world. The incidence of tuberculosis, once the greatest danger in an immigrant population, has been reduced to such a degree that the Canadian government, in some instances, has deliberately admitted cases of tuberculosis to Canada for treatment. Certain provincial governments have accepted a similar responsibility for tuberculosis cases.

A second factor of importance is the speed with which documents can today be transported and screened. One of the major reasons for introducing Canadian physicians into Europe was the delay consequent on the pre-screening technique. Documents can now be brought from any city in Europe to Ottawa almost as quickly as they can be taken to the European headquarters in London, where many reports of examinations now go for approval. The security investigations of the Department of Immigration are alleged to require an average of two weeks to complete. This period would provide ample time for evaluation in Ottawa of the results of local physical examinations in Europe.

Thus there are sound grounds for recommending that examinations abroad by Canadian physicians be discontinued altogether, and that roster doctors be employed in all countries. The present policy of providing free examinations for prospective immigrants of certain countries is of questionable value. Your Commissioners did not find evidence to support the apparent belief that the cost of the physical examination in any way affected the decision to emigrate.

Serious study should be given to developing a more objective type of examination. Modern needs would appear to include a continuation of x-rays for tuberculosis, to be read by physicians in Ottawa; urinalysis to be performed in a laboratory other than that of the examining physician; blood tests for syphilis, and the like. The present psychiatric staff should be used, with an advisory group, to produce an objective questionnaire to be filled out by the potential immigrant and evaluated in Ottawa. The findings of such a questionnaire should be followed carefully and constantly evaluated.

It is argued that the location of Canadian physicians in the field tends to minimize the danger of examination results being falsified by local physicians. However, the parts of the world in which this phenomenon is allegedly most likely to occur are not all at present staffed by Canadian physicians. Proper precautions will reduce the danger of bribery, and the selection of dependable physicians can best be accomplished with the advice of the local licensing body for physicians or the faculty of the local medical school.

In some centres there may be merit in following the example of Australia —in addition to employing full-time Australian doctors in London, Australian doctors following post-graduate training in England are employed on a part-time basis. This plan is considerably less expensive, has all the advantages of employing a national, and provides worthwhile assistance to young doctors.

We therefore recommend that:

1 More objective tests of prospective immigrants be developed, to include enquiries of a psychiatric nature.

2 The 'roster doctor' plan for carrying out examinations be universally applied, and the staff of Canadian physicians overseas be recalled.

3 Pending the implementation of the foregoing recommendation, the number of physicians now abroad be sharply reduced, and proper management controls be introduced in the Immigration Medical Service.

FOOD AND DRUGS

The Food and Drug Directorate administers the *Food and Drugs Act*, the *Proprietary or Patent Medicine Act*, and the *Opium and Narcotic Drug Act.*

The intent of these statutes is to ensure the purity of foods and the safety and effectiveness of drugs; to guide the public against health hazards in foods and drugs; to prevent fraudulent and deceptive labelling and advertising; and to regulate the importation, manufacture and distribution of narcotics.

The Directorate was established in 1875 and its scope has steadily increased. In recent years the volume of products appearing on the market and subject to scrutiny under the *Food and Drugs Act* has severely strained available resources. In 1960, some 25,000 radio commercials were checked; 2,000 of the 25,000 pharmaceutical products for sale in Canada were examined; some 200 new pharmaceuticals were investigated; and foods brought into Canada were inspected.

The Directorate, with headquarters in Ottawa, operates central laboratories in that city and in five regional offices across Canada which co-ordinate and direct the inspection of foods and drugs, with the exception of narcotics. The auditing of narcotic supplies in the drug trade is performed separately by eight inspectors, located at various points across the country, who are under the direct authority of the Chief, Narcotic Control Division, a unit only recently incorporated in the Directorate.

There is considerable honest doubt on the part of the inspection staff of this Directorate whether current responsibilities are being adequately met. The limited staff available results at times in a degree of superficiality of screening which can be dangerous, and staff requirements should therefore be carefully reviewed. Reference is made in the discussion of the Laboratory of Hygiene to the desirability of transferring to the Food and Drug Directorate the responsibility for analysis of biological drugs and inspection of manufacturing facilities.

We therefore recommend that: The analysis of biological drugs and the inspection of manufacturing facilities be henceforth administered by the Food and Drug Directorate.

5

CONSOLIDATION OF FEDERAL HEALTH SERVICES

The most efficient conduct of federal medical services cannot be achieved with fragmentation and separation of skilled manpower and facilities. Workloads vary unduly for personnel and equipment. In addition to the lack of correlation of activities of general medical officers, there is limited opportunity to make optimum use of special skills. Co-operation between the members of the various departments at the local or provincial levels is rendered needlessly difficult. In the federal government service, the various health divisions and directorates are more or less self-contained. Even though career opportunities may be singularly inadequate in certain parts of the Health Branch of the Department of National Health and Welfare, there is little opportunity for transfer. This extreme limitation of career opportunities accentuates problems of recruitment and strongly influences the quality of medical service.

The effect of the recommendations to transfer the operation of the majority of the federal hospitals to other jurisdictions will be to reduce the health services staff of the federal government by very significant proportions. When the transfer of hospitals has been completed, necessarily a long-term project, as many as 9,000 positions on the establishment of the Veterans Treatment Services Branch of the Department of Veterans Affairs and 1,500 in Indian and Northern Health Services of the Department of National Health and Welfare may be affected. The remaining federal employees engaged in health activities, excluding the Canadian Forces Medical Services, would number less than 5,000 (based on present strength). This number would exceed the

current strength of the Health Branch of the Department of National Health and Welfare by less than twenty-five per cent.

The logical step following the devolution of the medical care services and the consequent reduction in federal health personnel would be consolidation of the remaining services in one department.

REORGANIZATION OF HEALTH AND RELATED SERVICES

The top structure of the present Health Branch of the Department of National Health and Welfare is basically fitted to assume the reorganized functions. The continuation of three directorates is recommended, respectively consolidating:

- All activities and services designed to support and to co-ordinate the health services operating under provincial jurisdiction.
- All public health, diagnostic and treatment services provided by, or at the expense of, the federal government to persons whose health is primarily a federal responsibility or concern.
- All federal activities designed primarily to safeguard the public health through the control of the advertising, packaging and quality of foods and drugs, and of the distribution of narcotic drugs.

The proposed organization structure of a reconstituted Department of National Health and Welfare is illustrated in some detail in charts 3, 4, 5 and 6. Although future treatment service for veterans will, in the main, be furnished by part-time physicians on a fee basis, the remaining full-time staff should be part of this unified health service, as should the present health staff of the Penitentiaries Service. The medical evaluation required by the Canadian Pension Commission should be provided for in the reorganized Health Branch.

The changes outlined in the proposed structure are described elsewhere in this report, except for those pertaining to the proposed Medical and Treatment Services Directorate.

This Directorate will be executing several programmes for specified groups of veterans, Indians, and others. As far as possible, an integrated field staff will administer these programmes. It is desirable that specialists, concerned primarily with planning and control, should be provided to ensure that each programme is properly designed and executed by the Directorate. An Assistant Director, Programme Planning, should co-ordinate the activities of the programme specialists.

Chart 3—NATIONAL HEALTH AND WELFARE—RECOMMENDED ORGANIZATION OF THE HEALTH BRANCH

Minister of National Health and Welfare

Deputy Minister of National Health

Dominion Council of Health

Director, Health Services Directorate

Director, Medical and Treatment Services Directorate

Director, Food and Drug Directorate

Associate Director, Programme Planning and Appraisal

Research Co-Ordinator

Associate Director, Programme Planning and Appraisal

Statistical Unit

Medical Consultant

See Chart 4

See Chart 5

See Chart 6

Chart 4—HEALTH SERVICES DIRECTORATE

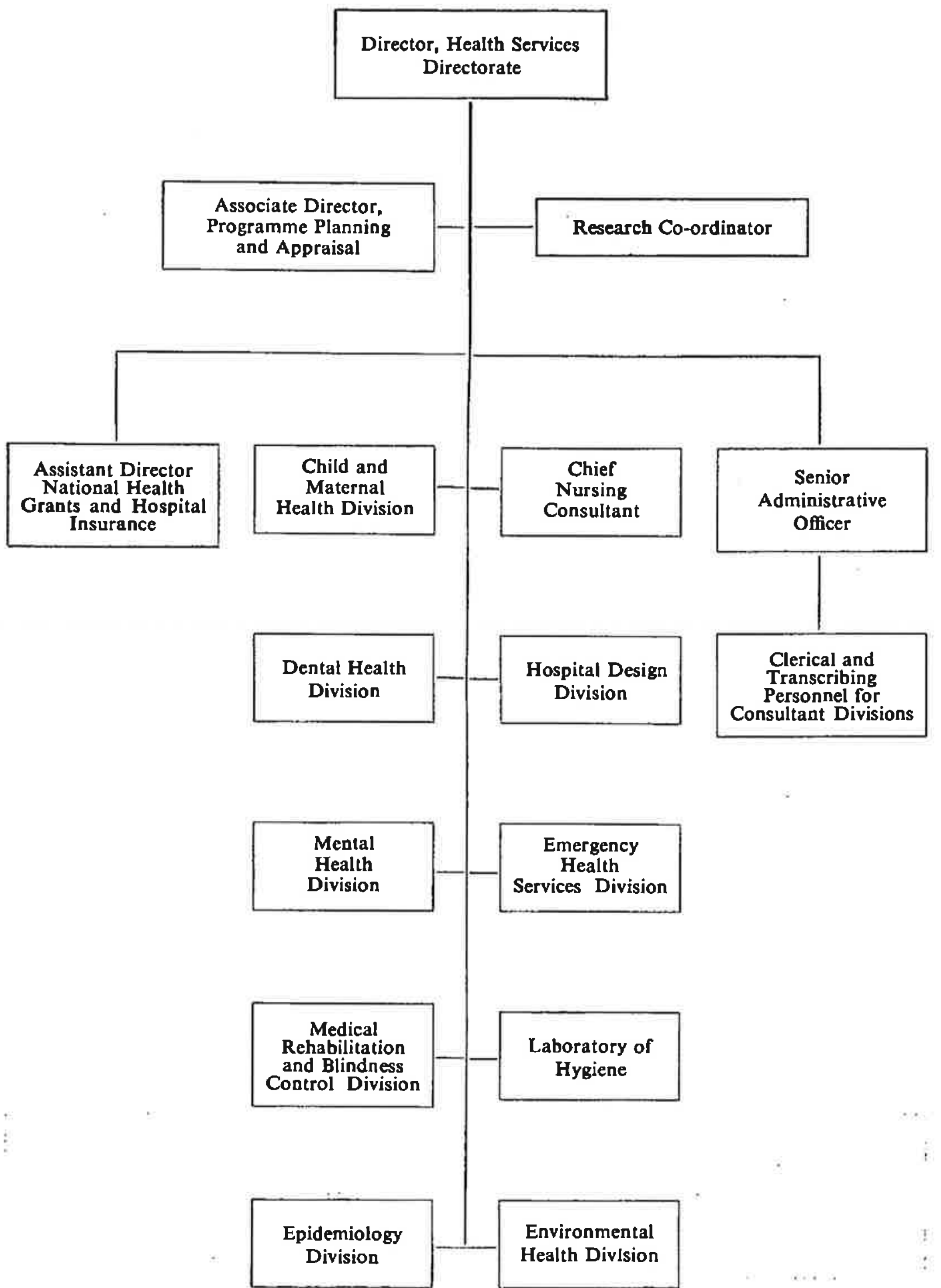


Chart 5—MEDICAL AND TREATMENT SERVICES DIRECTORATE

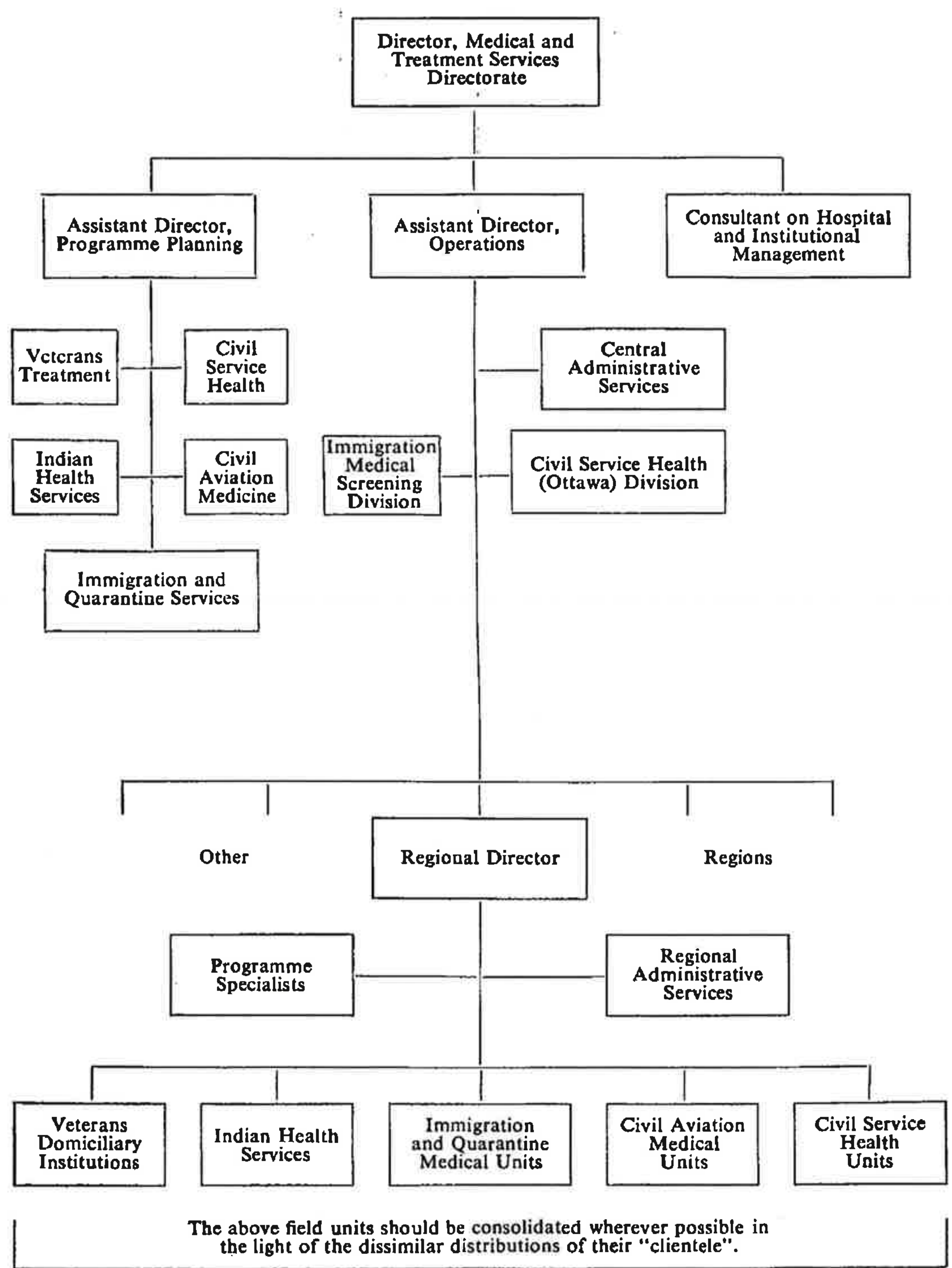
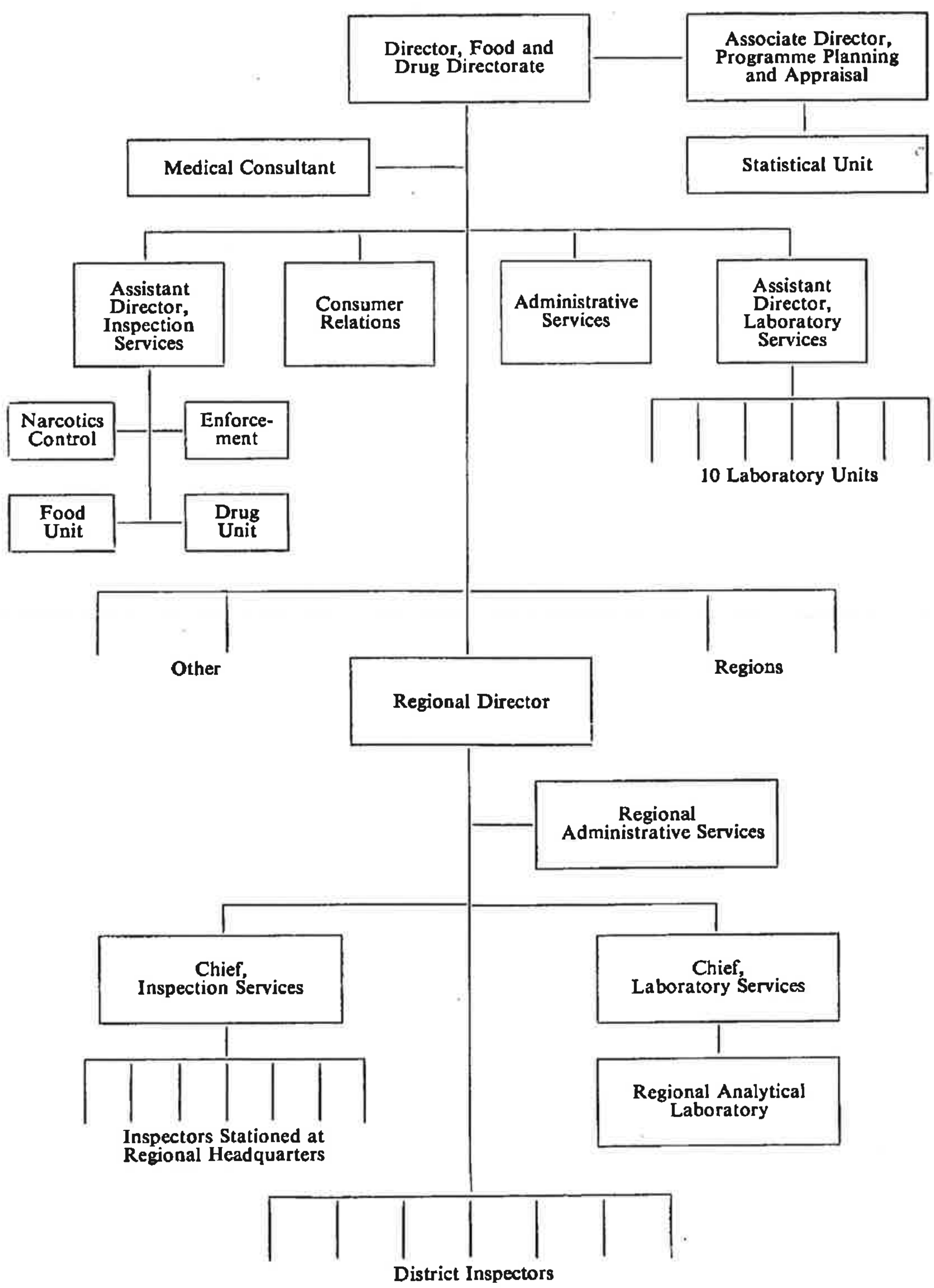


Chart 6—FOOD AND DRUG DIRECTORATE



One officer with extensive training and experience in hospital management should be appointed in a staff capacity to the Director, to ensure that the special problems of hospital management receive adequate attention within the Directorate.

An Assistant Director, Operations, is proposed to prevent the imposition of an over-extended span of control on the Director, to co-ordinate the relationships between regions, and to represent the operating units in the formulation of policies at the Directorate level.

Certain exceptions should be noted. In the north, the need for close co-ordination between public health and other public services (particularly education) leads to the conclusion that all government health services in each of the Territories should be under the control of the respective Commissioners. It is proposed, however, that the health personnel be rotated between the territorial civil services and the National Health Branch in order that a continuous supply of qualified persons can be made available to the Territories.

The incorporation of the Canadian Forces Medical Service within a unified health service was considered by your Commissioners. The assignment of civilian personnel from a central health service to serve with the Armed Forces, the special exigencies of war, and the control and discipline of servicemen receiving treatment in civilian facilities pose unique problems. The proposed consolidation of existing services in Veterans Affairs, National Health and Welfare, the Canadian Pension Commission, and the Penitentiaries Service should be completed before any decision is taken to incorporate any military personnel or facilities. This proposal does not preclude the seconding of civilian personnel from the Health Branch to the Canadian Forces Medical Service; conversely, health personnel retiring from the Armed Forces at an early age should be positively encouraged to join the civilian organization.

Once the federal health services have been successfully integrated, there would be advantages in developing a high degree of co-operation with provincial and municipal health services. Agreements for the interchange of staff would provide more opportunity for medical personnel and should thereby result in improved standards of care and a more attractive career for physicians. Recruiting difficulties for undesirable locations would be lessened, and greater staff mobility could be accomplished.

We therefore recommend that: All health services of the federal government other than the Canadian Forces Medical Service be consolidated in a reconstituted Health Branch of the Department of National Health and Welfare.

STAFFING

Although the formation of a single federal health service will in itself provide better career opportunities, concrete steps will have to be taken to encourage the best medical graduates to enter and remain in the public service. Acceptance and implementation of the recommendations contained in the report on *Personnel Management* will help to overcome the present cumbersome recruiting procedures and the barriers to transfer, but other factors remain which, unless approached positively, will continue to impede the enlistment of the best physicians. The opportunities for graduate training are limited. The heads of some of the specialist divisions have not had sufficient training to be certificated in their specialty. Salary ranges, unrealistic up to two years ago, have been significantly increased, but the problem has not been entirely removed.

The decline in the number of really good entrants to medical schools presents a serious problem to Canada as a whole. However, this a subject more properly within the reference to the Royal Commission on Health Services; therefore it is not now reviewed in detail, although of significance in staffing the public service.

6

MEDICAL RESEARCH

Medical research is considered here, apart from the report on *Scientific Research and Development*, because of its relationship to some of the activities in the field of medicine and public health dealt with in this report.

A comprehensive study of government-supported medical research in Canada was made several years ago by a committee of eminent doctors, under the chairmanship of Dr. R. F. Farquharson of the University of Toronto. The report of this Committee, submitted to the Government in November 1959, recommended the establishment of a Medical Research Council and an increase in the expenditures of public funds in support of medical research. These recommendations have been acted upon in part, and the Medical Research Council has been separately established under the aegis of the National Research Council for the time being.

Table 8—EXPENDITURES FOR MEDICAL RESEARCH IN 1961-62

	($000)
Department of National Health and Welfare	5,700
Defence Research Board	1,600
Medical Research Council	3,300
Department of Veterans Affairs	369
Queen Elizabeth Fund for Research into Diseases of Children	55
	11,024

In the year 1961-62, expenditures totalling $11 million were made by the government to support medical research. Five federal agencies were involved

and, of the total expenditures, approximately $7 million was disbursed in grants to universities and hospitals. The balance represents the cost of research conducted within the laboratories of three of the federal agencies concerned. Expenditures of the several agencies in 1961-62 are shown in Table 8.

DEPARTMENT OF NATIONAL HEALTH AND WELFARE—$5,700,000

Of the total medical research budget of the Department, $3.5 million is disbursed through the National Health Research grants. This programme is primarily devoted to public health and clinical medicine. Outside scientists advise the Department with respect to all such grants, and the screening operation appears to work effectively. The balance of the budget, $2 million, is spent to support the Department's own intramural programme which has expanded by nearly twenty-five per cent in the past two years. Here, individual projects are passed upon by groups of departmental officials without any independent advice from outside the public service. Your Commissioners, on the basis of their observation of other intramural research activities within the government, and in the absence of independent scrutiny of programmes, feel that a progressive increase may be expected in the proportion of the total funds available which is devoted to intramural research.

DEFENCE RESEARCH BOARD—$1,600,000

The same conflict is apparent between the support of outside projects and the growth tendencies of the Board's own laboratories. Grants made to universities are carefully screened by panels of experts drawn from all parts of Canada but no similar screening is applied to the intramural programme. Here again, the sums provided for the Board's own programmes have grown while the amounts available for outside research grants have diminished with the years.

THE MEDICAL RESEARCH COUNCIL—$3,300,000

Expenditures of the Council are devoted entirely to the support of research in universities and hospitals. The amount available in 1961-62 represents an increase of $1 million over the disbursements of the preceding year.

DEPARTMENT OF VETERANS AFFAIRS—$369,000

This small programme finances research in clinical medicine. While formerly an extramural programme was supported, the "in house" activities have grown

to a point where no funds were available for grants to outside bodies in the year 1960-61.

QUEEN ELIZABETH FUND FOR RESEARCH INTO DISEASES OF CHILDREN—$55,000

The activities of this Fund are confined to grants to young research workers in the field of child health to complete their training and qualify them as full-time research workers in universities and hospitals.

DIMENSIONS OF THE CANADIAN EFFORT

In the report on *Scientific Research and Development,* your Commissioners recommend means for the determination of national scientific and research policy. The proportion of total government research expenditures that should be devoted to medical research will be a matter for decision at ministerial level, with the advice of the proposed National Scientific Advisory Council. It is noteworthy that at the present time the support of research in the field of medicine claims but a modest (4½%) share of the government's total research expenditures. Monies spent on medical research in the United States are currently running at one hundred times the total of Canadian expenditures. This disproportion has become more accentuated in recent years as a result of a virtual explosion of activity in this field in the United States, which has had a significant effect upon the conduct of Canadian programmes. Facilities and salaries offered to medical scientists in the United States are on a lavish scale when compared with Canadian practice, and inevitably there has been a serious loss of Canadian trained scientists to the United States in recent years. There is no doubt that public funds are being applied in Canada to train scientists for the research programmes of the United States.

It is considered that, unless a substantial increase in support and facilities can be achieved in Canada, the standard of research activity may well suffer and the loss of trained personnel to the United States continue. In this context, the Farquharson report recommended the expenditure of $25 million for the creation of additional research facilities at Canadian universities and the granting of substantial annual increments to the budget for operating costs. A too rapid increase in the amount of money devoted to medical research can result in an imbalance between the integrated functions of research and teaching in the medical schools of the country. This danger was recognized by the Farquharson Committee and should be taken into account in the development of government policy in this area.

While the major portion of monies currently being spent by the government

is now devoted to financing research in the universities and hospitals, the several internal research activities display a tendency towards expansion which your Commissioners feel should be held in check. In general there is broad agreement that medical research should be conducted in the centres of medical education because of its effect on the increase in medical knowledge generally and on the training of medical workers. Properly to contain the activities of government laboratories, it will be necessary to establish a policy that no research be undertaken within government laboratories unless there are compelling reasons why it cannot be conducted at universities; in addition, the practice of submitting all "in house" activities for periodic screening or review by outside experts should be adopted.

7

ASPECTS OF FEDERAL GOVERNMENT HOSPITAL MANAGEMENT

Your Commissioners have recommended that the federal government withdraw progressively from the operation of hospitals, but some hospitals will be operated for many years. Recommendations in other reports of your Commissioners, particularly *Financial Management*, have a general bearing on hospital management, and certain other particular matters need attention.

HOSPITAL MANAGERS

Hospitals are complex organizations. To operate efficiently, they require the harmonious co-ordination of effort among diverse groups of people. Expensive facilities and large staffs must be utilized economically and, simultaneously, high standards of medical care must be maintained. These are the considerations that have led many large public and teaching hospitals to secure professionally qualified hospital managers as their senior executives. Federal hospitals, however, are managed by physicians, few of whom have had adequate preparatory training for the executive functions of their positions. Future appointments of hospital managers should be based on proven administrative ability in the hospital field and should not be restricted to physicians.

HOSPITAL SUPPORTING SERVICES

Certain services are rendered to federal hospitals by other departmental units, including functions such as personnel, purchasing, engineering and

budgetary control. In the Department of Veterans Affairs, the regional administrators are senior line executives in the field, responsible to the Deputy Minister for the management of veterans' welfare services and of central administrative groups within their regions. They also exercise, with certain exceptions, an authority over the personnel, purchasing, transport, accounting, and engineering functions within the hospitals. The Senior Treatment Medical Officer in each region is, nevertheless, held responsible "to the Director-General of Treatment Services" (at headquarters) "for providing complete medical, prosthetic, dental, hospital and domiciliary care to veterans and other persons . . . .".* The hospital administrator is dependent on these outside officers and subject to the rules and regulations of an outside authority. Where authority is so divided, no one can be fully accountable.

For example, the centralization of purchase authority in regions or districts frequently results in contracts being awarded to other than local firms, even when local prices, quality and service are comparable. Consequently, difficulties arise through shortages and non-delivery. Central purchase of certain common goods is obviously justified because of the very significant economies available through bulk purchasing. The items to be purchased centrally should, however, be designated in an up-to-date catalogue, and rapid delivery must be assured. The hospital administrator must have the authority to purchase any item locally in an emergency.

Wherever feasible, all essential administrative services must be co-ordinated within the hospital under the authority and control of the hospital manager, subject only to broad guidelines.

FINANCIAL MANAGEMENT AND CONTROL

Estimates

The inadequacy of the information currently provided to Parliament in the Estimates is stressed in the report on *Financial Management.* Some specific comment is required on hospital estimates and financial control. In no case are the anticipated expenditures for individual hospitals disclosed in the Estimates. In general, the anticipated cost of operating all hospitals in any department is combined in one vote in the Estimates, often grouped with other expenditures, and is categorized only under "standard objects of expenditure", such as salaries, rental of equipment, and postage, which indicate the nature of the expenditure but not its purpose. The hospital department-heads responsible for expenditures often do not participate in the preparation of the

*D.V.A. Departmental Instructions, October, 1961.

Estimates. The principal guide in arriving at the forecasts is the historical record, and this is the primary reference of those who review the Estimates. The individual hospital estimates are consolidated, reviewed and often reduced by headquarters staff. Hospitals are not always advised of the revised amounts within which they are expected to operate.

Hospital programmes presented to the Treasury Board and Parliament for approval should show the total estimated costs of each individual hospital. The estimated costs of certain smaller institutions or centres could probably be combined for Parliament but should be submitted individually to the Treasury Board for review. Individual hospital estimates should originate with hospital management.

Expenditure Control

Generally accepted principles of management control require that individual managers be held accountable for expenditures incurred on their authority. Decisions of department heads in a hospital obviously have a direct effect on the operating costs of their respective departments and of the hospital. However, expenditures are now controlled not by areas of operating responsibility but by the same standard objects of expenditures as are used in compiling the Estimates. At the hospital level, this necessarily places the onus of control on the senior accounting or administrative officer and not on the department heads, on whose decisions expenditures depend. In practice, little control is exercised until the latter months of the year, when accumulated expenditures approach the original amounts estimated. At this point, some departments within the hospital may suffer because of inefficiencies or mismanagement in others.

The Estimates are now prepared and expenditures controlled under the government's standard cash accounting system. An accrual system is required, both to satisfy the needs of management and as a basis for proper financial reporting. The adoption of the standard accounting system developed by the Canadian Hospital Association, which is used today by most Canadian hospitals, would not only lead to improved management but would enable the government to set standards for its own operations by comparison with a wide variety of private institutions.

Improved financial information for management control purposes should be available both in hospitals and at headquarters. Comprehensive monthly statements should be prepared showing comparisons of actual and budgeted costs and the amounts of variances. Some hospitals,—e.g., Royal Canadian Navy Hospital Naden in Esquimalt, B.C.—have no reliable cost information, nor is it available at headquarters. At Sunnybrook Hospital, a cost statement

for the fiscal year 1959-60 was released only in March 1961, long after it could have served any useful purpose.

INVENTORY MANAGEMENT

Inventory management in government hospitals is less than satisfactory. There are no uniform policies for establishing the minimum and maximum quantities that should be on hand; where limits have been set at the local level, control is not always exercised to assure adherence to those limits. Also, the clerical effort put forth is inefficient and uneven; stores of low monetary value receive the same attention as expensive supplies.

Hospital stores should be financed through the use of a revolving fund. This would provide additional flexibility and avoid the year-end rush to spend remaining funds that would otherwise lapse. It would also facilitate the use of accrual accounting for management purposes and permit accurate costing procedures.

No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

WOLF WILLIAM SOLKIN

Plaintiff

vs.

THE ATTORNEY GENERAL OF CANADA

-and-

THE ATTORNEY GENERAL OF QUEBEC

-and-

THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

LIST OF EXHIBITS AGC-1 TO AGC-25
IN SUPPORT OF THE DEFENCE
OF THE ATTORNEY GENERAL OF CANADA

EXHIBIT AGC-1

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O/Ref : 9683661 BC0565

Québec

Gouvernement du Québec
Ministre de la Santé et des Services sociaux

Québec, le 16 juillet 2009

L'honorable Greg Thompson
Ministre des Anciens Combattants
Anciens Combattants Canada
14e étage
66, rue Slater
Ottawa (Ontario) K1A 0P4

Monsieur le Ministre,

La présente fait suite à la lettre que vous m'avez fait parvenir le 26 juin dernier dans laquelle vous souhaitiez vérifier l'intérêt du gouvernement du Québec à procéder à un éventuel transfert de propriété de l'Hôpital Sainte-Anne.

Le transfert de l'hôpital permettrait aux résidents de la région de bénéficier de soins de qualité et de profiter de l'expertise du personnel tout en demeurant au sein de leur communauté étant donné les besoins décroissants des anciens combattants.

C'est donc dans ce contexte que je vous confirme l'intérêt du gouvernement du Québec à débuter des négociations visant à procéder au transfert graduel de cet établissement.

En dernier lieu, je partage votre désir d'entamer les discussions le plus rapidement possible afin d'arriver à conclure une entente satisfaisante pour les deux parties dans un avenir rapproché.

Je vous prie d'agréer, Monsieur le Ministre, l'expression de mes sentiments les meilleurs.

Le ministre,

Yves Bolduc

N/Réf. : 09-MS-02916

Québec
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No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

WOLF WILLIAM SOLKIN

Plaintiff

vs.

THE ATTORNEY GENERAL OF CANADA

-and-

THE ATTORNEY GENERAL OF QUEBEC

-and-

THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

LIST OF EXHIBITS AGC-1 TO AGC-25
IN SUPPORT OF THE DEFENCE
OF THE ATTORNEY GENERAL OF CANADA

EXHIBIT AGC-2

Attorney General of Canada

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O/Ref : 9683661 BC0565

AGC-3

Français

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PC Number: 2009-1954

Date: 2009-12-03

Whereas the Government of Canada is committed to continue responding to the changing needs and demographics of veterans, including by ensuring an appropriate capacity of long-term care beds and programming for the future;

Whereas there is a declining federal need for Ste. Anne's Hospital and anticipated increasing need in the Province of Quebec for long-term care beds;

And whereas the Government of Canada and the Government of Quebec have agreed to enter into negotiations for the transfer of Ste. Anne's Hospital to provincial authorities;

Therefore, Her Excellency the Governor General in Council, on the recommendation of the Prime Minister, pursuant to paragraph 127.1(1)(*c*) of the *Public Service Employment Act* , hereby appoints to the position of special adviser to the Minister of Veterans Affairs, Richard Joseph Neville of Ottawa, Ontario, as Chief

Negotiator, Ste. Anne's Hospital Transfer Project, to hold office during pleasure for a term of three years, and fixes his remuneration as set out in the annexed schedule, which remuneration is within the per diem range ($1,000 - $1,200).

Attendu que le gouvernement du Canada est résolu à continuer de répondre aux besoins et à la démographie en constante évolution des anciens combattants, notamment en garantissant un nombre adéquat de lits de soins de longue durée et en prévoyant les besoins futurs;

Attendu que la demande fédérale de soins à l'hôpital Sainte-Anne diminue et que les besoins du Québec en matière de soins de longue durée devraient s'accroître;

Attendu que les gouvernements du Canada et du Québec ont convenu d'entamer des négociations concernant le transfert de l'hôpital Sainte-Anne à l'administration provinciale,

À ces causes, sur recommandation du premier ministre et en vertu de l'alinéa 127.1(1) *c)* de la *Loi sur l'emploi dans la fonction publique* , Son Excellence la Gouverneure générale en conseil nomme au poste de conseiller spécial auprès du ministre des Anciens Combattants, Richard Joseph Neville, d'Ottawa (Ontario), en qualité de négociateur en chef pour le projet de transfert de l'hôpital Sainte-Anne, à titre amovible, pour un mandat de trois ans, et fixe le taux

journalier de sa rémunération dans l'échelle (1 000 $ - 1 200 $), conformément à l'annexe ci-jointe.

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PC Number: 2012-1616

Date: 2012-11-30

His Excellency the Governor in Council, on recommendation of the Prime Minister, pursuant to paragraph 127.1(1)(c) of the *Public Service Employment Act*, amends
Order in Council P.C. 2009-1954 of December 3, 2009 by replacing "for a term of three years" by "for a term ending March 31, 2013".

Sur recommandation du premier ministre et en vertu de l'alinéa 127.1(1)*c*) de la *Loi sur l'emploi dans la fonction publique*, Son Excellence le Gouverneur Général en conseil modifie le décret C.P. 2009-1954 du 3 décembre 2009 en remplaçant « pour un mandat de trois ans » par « pour un mandat se terminant le 31 mars 2013 ».

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Français

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PC Number: 2013-0410

Date: 2013-04-22

Whereas the Government of Canada is committed to continue responding to the changing needs and demographics of veterans, including by ensuring an appropriate capacity of long-term care beds and programming for the future;

Whereas there is a declining federal need for Ste. Anne's Hospital and anticipated increasing need in the Province of Quebec for long-term care beds;

And whereas the Government of Canada and the Government of Quebec have agreed to enter into negotiations for the transfer of Ste. Anne's Hospital to provincial authorities;

Therefore, His Excellency the Governor General in Council, on the recommendation of the Prime Minister, pursuant to paragraph 127.1(1)(*c*) of the *Public Service Employment Act*, reappoints to the position of special adviser to the Minister of Veterans Affairs, Richard Joseph Neville of Ottawa, Ontario, as Chief Negotiator, Ste. Anne's Hospital Transfer Project, to hold office during pleasure for a term ending December 31, 2013, and fixes his remuneration as set out in the annexed schedule, which remuneration is within the per diem range ($1,000 -

$1,200).

Attendu que le gouvernement du Canada est résolu à continuer de répondre aux besoins et à la démographie en constante évolution des anciens combattants, notamment en garantissant un nombre adéquat de lits de soins de longue durée et en prévoyant les besoins futurs;

Attendu que la demande fédérale de soins à l'hôpital Sainte-Anne diminue et que les besoins du Québec en matière de soins de longue durée devraient s'accroître;

Attendu que les gouvernements du Canada et du Québec ont convenu d'entamer des négociations concernant le transfert de l'hôpital Sainte-Anne à l'administration provinciale,

À ces causes, sur recommandation du premier ministre et en vertu de l'alinéa 127.1(1)*c)* de la *Loi sur l'emploi dans la fonction publique*, Son Excellence le Gouverneur général en conseil nomme de nouveau au poste de conseiller spécial auprès du ministre des Anciens Combattants, Richard Joseph Neville, d'Ottawa (Ontario), en qualité de négociateur en chef pour le projet de transfert de l'hôpital Sainte-Anne, à titre amovible, pour un mandat se terminant le 31 décembre 2013, et fixe le taux journalier de sa rémunération dans l'échelle (1 000 $ - 1 200 $), conformément à l'annexe ci-jointe.

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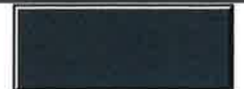

PC Number: 2014-0155

Date: 2014-02-18

Whereas the Government of Canada is committed to continue responding to the changing needs and demographics of veterans, including by ensuring an appropriate capacity of long-term care beds and programming for the future;

Whereas there is a declining federal need for Ste. Anne's Hospital and anticipated increasing need in the Province of Quebec for long-term care beds;

And whereas the Government of Canada and the Government of Quebec have agreed to enter into negotiations for the transfer of Ste. Anne's Hospital to provincial authorities;

Therefore, His Excellency the Governor General in Council, on the recommendation of the Prime Minister, pursuant to paragraph 127.1(1)(*c*) of the *Public Service Employment Act*, reappoints to the position of special adviser to the Minister of Veterans Affairs, Richard Joseph Neville of Ottawa, Ontario, as Chief Negotiator, Ste. Anne's Hospital Transfer Project, to hold office during pleasure for a term ending March 31, 2014, and fixes his remuneration as set out in the annexed schedule, which remuneration is within the per diem range ($1,000 - $1,200).

Attendu que le gouvernement du Canada est résolu à continuer de répondre aux besoins et à la démographie en constante évolution des anciens combattants, notamment en garantissant un nombre adéquat de lits de soins de longue durée et en prévoyant les besoins futurs;

Attendu que la demande fédérale de soins à l'hôpital Sainte-Anne diminue et que les besoins du Québec en matière de soins de longue durée devraient s'accroître;

Attendu que les gouvernements du Canada et du Québec ont convenu d'entamer des négociations concernant le transfert de l'hôpital Sainte-Anne à l'administration provinciale,

À ces causes, sur recommandation du premier ministre et en vertu de l'alinéa 127.1(1)*c)* de la *Loi sur l'emploi dans la fonction publique*, Son Excellence le Gouverneur général en conseil nomme de nouveau au poste de conseiller spécial auprès du ministre des Anciens Combattants, Richard Joseph Neville, d'Ottawa (Ontario), en qualité de négociateur en chef pour le projet de transfert de l'hôpital Sainte-Anne,
à titre amovible, pour un mandat se terminant le 31 mars 2014, et fixe le taux journalier de sa rémunération dans l'échelle (1 000 $ - 1 200 $), conformément à l'annexe ci-jointe.

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Defendants

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O/Ref : 9683661 BC0565

Anciens Combattants Canada — Veterans Affairs Canada

Notes d'allocution à l'intention de **L'HONORABLE**

Speaking notes for **THE HONOURABLE**

Jean-Pierre Blackburn

Ministre des Anciens Combattants
Ministre d'État (Agriculture)

Minister of Veterans Affairs
Minister of State (Agriculture)

Notes d'allocution

Conférence de presse de l'Hôpital Sainte-Anne

Le 26 avril 2010
Hôpital Sainte-Anne
Sainte-Anne-de-Bellevue (Québec)
Heure d'arrivée : Heure
Début de l'activité : Heure
Début de l'allocution : Heure
Durée de l'activité : XX heures XX minutes

Le discours prononcé fait foi

Please check against delivery

Merci [Maître de cérémonie] XXXX.

Chère Mme Corneille Gravel,
Représentants des médias.

Bonjour.

C'est un honneur pour moi d'être des vôtres, aujourd'hui, à l'Hôpital Sainte-Anne, une institution qui jouit d'une longue et fière tradition.

Comme vous le savez, notre Ministère est fermement engagé à l'endroit des anciens combattants et des vétérans. Nous sommes reconnaissants des sacrifices qu'ils ont faits pour notre pays. Notre mandat premier est de leur

témoigner toute la gratitude qu'ils méritent, pour les courageux efforts qu'ils ont déployés.

Bien sûr, l'Hôpital Sainte-Anne est un dossier qui nous intéresse tous, qui touche de près beaucoup de monde. Je tiens à vous assurer, ce matin, que c'est un sujet que j'ai tout autant à cœur. C'est d'ailleurs précisément pour cette raison que j'ai décidé de venir vous rencontrer, aujourd'hui, pour faire une mise à jour des dernières informations liées à ce dossier.

Pour retracer l'importante histoire de l'institution, l'Hôpital Sainte-Anne a été édifié en 1917 par la Commission des hôpitaux militaires, en guise de

reconnaissance envers les hommes et les femmes qui ont combattu au cours de la Première Guerre mondiale.

Après la Seconde Guerre mondiale, Anciens Combattants Canada a acquis et exploité ses propres hôpitaux en raison des besoins très particuliers que nécessitaient les anciens combattants, ainsi que des limites dans les soins publics offerts et des variantes rencontrées d'une communauté à l'autre.

Depuis les années 60 toutefois, le gouvernement du Canada a pour politique de transférer ses hôpitaux aux provinces. En fait, il en est ainsi depuis l'entrée

en vigueur de la Loi canadienne sur la santé et du régime national d'assurance-maladie qui ont fait passer la santé sous la juridiction provinciale.

À ce jour, 17 établissements administrés par Anciens Combattants Canada ont été transférés aux provinces. Les transferts précédents ont été couronnés de succès, car ils ont été faits dans le plus grand respect des anciens combattants et de leurs familles, avec comme toile de fond le grand souci de protéger leurs intérêts.

L'Hôpital Sainte-Anne est donc le dernier hôpital dédié aux anciens combattants de propriété fédérale.

[APG]

Depuis plusieurs années, la demande de lits par les anciens combattants traditionnels pour des soins de longue durée connaît une diminution importante et continue. Si nous ne faisons rien, il y aura malheureusement de plus en plus de lits vacants dans cet hôpital.

L'Hôpital Sainte-Anne est un établissement d'avant-garde dont l'expertise unique est précieuse. Pour notre Ministère comme pour la population en général, il est important, que cette expertise se perpétue. Il nous faut donc activement préparer notre avenir.

C'est précisément pour cette raison que le Ministère a entamé des discussions avec le gouvernement du Québec au sujet d'un potentiel transfert de l'Hôpital à la province. Selon les prévisions, en 2015 il pourrait y avoir 214 lits excédentaires à l'Hôpital. Cela pourrait entraîner une perte d'expertise et de main-d'œuvre au sein de l'établissement.

Si nous ne prenions pas nos responsabilités, la situation pourrait menacer notre engagement même envers les anciens combattants et le niveau de soins et services exceptionnels qui leur sont offerts.

L'Hôpital Sainte-Anne est un établissement d'avant-garde dont l'expertise unique est enviable.

[APG]

Il est important pour notre Ministère, et pour la population en général, que cette expertise demeure. Si nous voulons qu'il en soit ainsi, nous devons penser à l'avenir. C'est précisément pour cette raison que le Ministère a entamé des discussions avec le gouvernement du Québec.

En 2009, le gouvernement du Canada a pressenti le gouvernement du Québec afin de voir s'il y avait un intérêt à discuter d'un transfert potentiel, ce que Québec a confirmé.

En fait, un transfert aurait des avantages à long terme pour les anciens combattants, pour le personnel de l'Hôpital et pour la population québécoise.

Actuellement, les soins de longue durée à l'Hôpital Sainte-Anne sont destinés aux anciens combattants de la Seconde Guerre mondiale et aux anciens combattants de la Guerre de Corée.

L'Hôpital compte présentement 415 résidents dont la moyenne d'âge est de 87 ans.

[APG]

Les vétérans de l'ère moderne ou les soldats souffrant de blessures ont, généralement, besoin de soins aigus ou de services de réadaptation qui leur sont offerts dans des centres de soins de santé situés dans leur communauté.

L'Hôpital Sainte-Anne, qui est un centre de soins de longue durée spécialisé en gériatrie et en psychogériatrie, voit donc ses lits majoritairement occupés par une clientèle vieillissante.

L'Hôpital Sainte-Anne offre toute une gamme de soins et de services en santé mentale aux vétérans de l'ère moderne, y compris des services d'hébergement thérapeutique de courte durée.

[APG]

Toutefois, les besoins en soins aigus des vétérans de l'ère moderne ne peuvent tout simplement pas êtres comblés à l'Hôpital Sainte-Anne.

Certains d'entre vous avez peut-être entendu parler d'une liste d'attente pour être admis à l'Hôpital Sainte-Anne alors qu'il y a un déclin de la clientèle.

À ce sujet, je tiens à apporter des nuances importantes. D'abord, les anciens combattants attendent très peu avant d'être admis à l'Hôpital Sainte-Anne. Dans la majorité des cas, ils sont admis à l'intérieur de deux à quatre semaines. Néanmoins, nous devons nous assurer que les anciens combattants qui arrivent à l'Hôpital Sainte-

[APG]

Anne sont admis dans le programme qui répond le mieux à leurs besoins. Donc, selon le type de programme dont l'ancien combattant a besoin, il peut arriver qu'il n'y ait pas de lits de disponibles immédiatement, au moment de sa demande. Mais je peux vous assurer que malgré tout, les demandes sont traitées promptement, et que le délai d'admission à l'Hôpital Sainte-Anne est très court, surtout si on le compare à ceux des autres établissements. Enfin, peu importe l'avenir, ce qui importe pour le gouvernement du Canada est de nous assurer que les anciens combattants hospitalisés à Sainte-Anne continueront de bénéficier d'un accès prioritaire aux soins

[APG]

exceptionnels auxquels ils sont en droit de s'attendre.

À ce jour, les discussions avec Québec en sont au stade préliminaire et les négociations officielles n'ont toujours pas été entamées. Les négociations peuvent s'avérer complexes et nécessiter un temps considérable. Ceci dit, nous nous sommes engagés à faire ce qu'il fallait, et nous allons agir dans le plus grand souci des besoins de notre clientèle et de notre personnel.

Nous en sommes aux premiers balbutiements des discussions. Des rencontres initiales ont été organisées en 2009 afin de discuter du travail

[APG]

préparatoire nécessaire à la négociation d'un transfert potentiel.

En décembre 2009, Monsieur Richard J. Neville, F.C.A., a été nommé à titre de négociateur en chef. Son mandat est de mener les négociations au nom du gouvernement du Canada en vue d'un transfert potentiel de l'Hôpital Sainte-Anne au gouvernement du Québec.

M. Neville a occupé plusieurs postes supérieurs au sein de la Fonction publique du Canada. Il été impliqué dans le transfert de l'Hôpital Charles Camsell.

[APG]

Il a débuté sa carrière comme analyste des systèmes financiers et contrôleur à Santé et Bien-être social Canada.

Depuis sa nomination, Monsieur Neville discute avec les parties intéressées, les syndicats et les employés. Il prépare également la prise de position du gouvernement du Canada en ce qui concerne la protection des intérêts des résidents et des employés.

Au cours de sa carrière, Monsieur Neville a occupé divers postes de niveau supérieur à Approvisionnements et Services Canada dont celui de directeur général régional des régions de Québec

[APG]

et de l'Ouest. Il a occupé plusieurs postes de sous-ministre adjoint (ASC, Travaux Publics et Services gouvernementaux Canada) et contrôleur général adjoint et Secrétaire adjoint au Conseil du Trésor du Canada.

Il a également été vice-président (Finances et Administration) et directeur financier de la Monnaie royale canadienne. Monsieur Neville a pris sa retraite de la Fonction publique en 2008.

Le gouvernement du Canada s'est donné plusieurs priorités tout au long des discussions et des négociations.

[APG]

Le gouvernement veut s'assurer que nos anciens combattants maintiennent leur priorité d'accès à l'Hôpital Sainte-Anne ainsi qu'aux soins de santé exceptionnels dont ils bénéficient et qu'ils méritent. Nous voulons également veiller à permettre l'accès à des services et à des soins de santé dans la langue officielle de leur choix.

Le bilinguisme est – et continuera de constituer – un élément clé des négociations. Lors de transferts précédents, Anciens Combattants Canada a obtenu des garanties afin de s'assurer que les soins seraient dispensés dans la langue officielle choisie par les anciens combattants. Ces garanties sont applicables dans les institutions où le bilinguisme est

[APG]

primordial. Pour certaines autres institutions qui ont été transférées par le passé, le bilinguisme n'était pas un facteur.

Le Centre national pour traumatismes liés au stress opérationnel (CNTSO) fait partie intégrante du programme de santé mentale d'Anciens Combattants Canada. Le Ministère continuera à administrer le CNTSO et maintiendra l'expertise qui y a été développée dans le domaine de la santé mentale.

Anciens Combattants Canada continue d'offrir les services du Centre de jour et, dans le cadre des négociations, veillera à s'assurer que ces services

continueront d'être offerts tant qu'il y aura un besoin pour les anciens combattants.

Le gouvernement a également à cœur les intérêts des employés. Nous nous sommes engagés à tenir les syndicats bien informés, et ce, tout au long du processus. D'ailleurs, nous avons rencontré les représentants syndicaux à plusieurs reprises au cours des derniers mois, et nous allons continuer à le faire.

Nous travaillons de concert avec les syndicats sur un cadre de consultation afin qu'ils puissent être consultés au moment où les négociations officielles seront lancées.

[APG]

À l'Hôpital Sainte-Anne, il y a une décroissance constante de demandes de soins de longue durée compte tenu de la décroissance du nombre d'anciens combattants.

Afin de protéger nos employés et de veiller au maintien de l'expertise de l'Hôpital, un volet des discussions préliminaires que nous avons entreprises avec le gouvernement du Québec touche l'admission de civils pour des soins de longue durée en gériatrie et en psychogériatrie.

Il est possible que nous puissions conclure une entente à ce sujet dans une phase transitoire, avant qu'un transfert potentiel ne soit conclu.

[APG]

Le transfert de l'Hôpital Sainte-Anne à la Province de Québec contribuerait à maintenir son expertise unique dans les domaines de la gériatrie et de la psychogériatrie.

De plus, on augmenterait la disponibilité de lits pour d'autres Canadiens dans le besoin tout en nous assurant que les besoins des anciens combattants soient traités en priorité.

Je sais que le transfert de l'Hôpital Sainte-Anne est un dossier qui tient beaucoup de monde en haleine, et c'est tout à fait compréhensible. C'est pourquoi je m'engage, et ce, tout au long du processus, à vous tenir bien informés.

[APG]

Je suis ici pour vous partager les dernières nouvelles liées au dossier, et aussi pour entendre vos préoccupations et vos questions. Il me fera plaisir d'y répondre au meilleur de mes connaissances.

Merci.

– 30 –

Word count : 1,757 words (15 minutes)

[APG]

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Defendants

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EXHIBIT AGC-4

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O/Ref : 9683661 BC0565

Minister
of Veterans Affairs and
Minister of State (Agriculture)

Ministre
des Anciens Combattants et
ministre d'État (Agriculture)

Ottawa, Canada K1A 0P4

NOV 2 9 2010

Monsieur Yves Bolduc
Ministre de la Santé et des Services sociaux
Édifice Catherine-de-Longpré
1075, chemin Sainte-Foy, 15e étage
Québec (Québec)
G1S 2M1

Monsieur le Ministre,

La présente donne suite à notre correspondance antérieure concernant le transfert éventuel de l'Hôpital Sainte-Anne à la province de Québec. Je vous sais gré d'avoir confirmé, dans votre lettre datée du 16 juillet 2009, que le gouvernement du Québec est intéressé à entamer dès que possible un processus de négociation en vue du transfert de cet hôpital afin de mieux répondre aux besoins des résidents de la région.

Je suis content que des contacts aient eu lieu entre le négociateur en chef, M. Richard J. Neville, FCA, et Mme Lise Verreault, sous-ministre associée au ministère de la Santé et des Services sociaux, qui assure la représentation de votre ministère dans ce processus. Une rencontre entre M. Neville et Mme Verreault est donc prévue à Québec pour

.../2

le 1er décembre, laquelle portera sur le programme et le calendrier des négociations. Cette réunion est importante pour l'avancement du dossier. Nous nous réjouissons à l'avance de pouvoir entamer le processus de négociation officiel dans les meilleurs délais par suite de cette première rencontre.

Je vous prie d'agréer, Monsieur, mes salutations les meilleures.

Jean-Pierre Blackburn, C.P., député

RECEIVED

Québec

c.c. to MINO JAN 1 9 2011

JAN 1 9 2011

Gouvernement du Québec
Ministre de la Santé et des Services sociaux

Executive Services Unit
JAN 1 9 2010
Direction des services exécutifs

Québec, le 11 janvier 2011

L'honorable Jean-Pierre Blackburn
Ministre des Anciens Combattants
et ministre d'État (Agriculture)
Anciens Combattants Canada
66, rue Slater, 14e étage
Ottawa (Ontario) K1A 0P4

Monsieur le Ministre,

J'ai pris connaissance de votre lettre du 29 novembre 2010 au sujet des discussions entre nos deux gouvernements concernant l'Hôpital Sainte-Anne, le dernier hôpital pour anciens combattants au Québec, dont le gouvernement fédéral souhaite transférer la propriété au gouvernement du Québec. Je suis heureux de constater que, tout comme moi, vous portez une attention particulière à ce dossier.

Tel que noté dans votre lettre, une première rencontre préalable a effectivement eu lieu entre le négociateur en chef du gouvernement fédéral et madame Lise Verreault, sous-ministre associée au ministère de la Santé et des Services sociaux, au sujet d'un éventuel transfert de l'Hôpital Sainte-Anne.

Je partage votre souhait de voir les négociations s'amorcer dans les meilleurs délais dans ce dossier.

Veuillez agréer, Monsieur le Ministre, l'expression de mes sentiments les meilleurs.

Le ministre,

Yves Bolduc

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No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

WOLF WILLIAM SOLKIN

Plaintiff

vs.

THE ATTORNEY GENERAL OF CANADA

-and-

THE ATTORNEY GENERAL OF QUEBEC

-and-

THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

LIST OF EXHIBITS AGC-1 TO AGC-25
IN SUPPORT OF THE DEFENCE
OF THE ATTORNEY GENERAL OF CANADA

EXHIBIT AGC-5

Attorney General of Canada

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AGC-6

AGRÉMENT CANADA

Force motrice de la qualité des services de santé

Rapport d'agrément

Hôpital Sainte-Anne

Sainte-Anne-de-Bellevue, QC

Dates de la visite : 6 au 9 septembre 2011

Date de production du rapport : 17 janvier 2012

Driving Quality Health Services
Force motrice de la qualité des services de santé

Agréé par ISQua

Au sujet du rapport

Hôpital Sainte-Anne (nommé «l'organisme» dans le présent rapport) participe au programme Qmentum d'Agrément Canada. Dans le cadre de ce processus permanent d'amélioration de la qualité, une visite a eu lieu en septembre 2011. Ce rapport d'agrément repose sur l'information obtenue dans le cadre de cette visite et sur d'autres données fournies par l'organisme.

Les résultats du processus d'agrément sont fondés sur l'information reçue de l'organisme. Agrément Canada se fie à l'exactitude des renseignements qu'il a reçus pour planifier et mener la visite d'agrément, ainsi que pour préparer le rapport d'agrément.

Toute modification du rapport d'agrément compromettrait l'intégrité du processus d'agrément et est strictement interdite.

Confidentialité

Le présent rapport est confidentiel et fourni par Agrément Canada uniquement à l'organisme. Agrément Canada ne présente ce rapport à aucune autre partie.

En vue de favoriser la transparence et la reddition de compte, Agrément Canada encourage l'organisme à divulguer le contenu de son rapport d'agrément au personnel, aux membres du conseil d'administration, aux clients, à la communauté et aux autres partenaires.

Agrément Canada est un organisme sans but lucratif et indépendant qui fournit aux organismes de services de santé un processus d'agrément rigoureux et exhaustif. Il favorise l'amélioration continue de la qualité au moyen de normes fondées sur des données probantes et d'un examen mené par des pairs de l'externe. Agréé par l'International Society for Quality in Healthcare, Agrément Canada aide les organismes à viser l'excellence depuis plus de 50 ans.

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Un mot de la présidente-directrice générale d'Agrément Canada

Au nom du conseil d'administration et du personnel d'Agrément Canada, je tiens à féliciter chaleureusement votre conseil d'administration, votre équipe de direction et tout le monde de Hôpital Sainte-Anne d'avoir participé au Programme d'agrément Qmentum. Le programme Qmentum est conçu de manière à s'intégrer à votre programme d'amélioration de la qualité. En l'utilisant pour appuyer et favoriser vos activités d'amélioration de la qualité, vous l'utilisez à sa pleine valeur.

Le présent rapport d'agrément comprend le type d'agrément qui vous est décerné, ainsi que les résultats finaux de votre récente visite, de même que les données découlant des outils que votre organisme a soumis. Veuillez utiliser l'information contenue dans ce rapport et dans votre plan d'amélioration de la qualité du rendement, disponible en ligne, pour vous guider dans vos activités d'amélioration.

Si vous avez des questions ou si vous voulez des conseils, n'hésitez pas à communiquer avec votre spécialiste en agrément.

Je vous remercie du leadership et de l'engagement continu que vous témoignez à l'égard de la qualité en intégrant l'agrément à votre programme d'amélioration. C'est avec plaisir que nous recevrons vos commentaires sur la façon dont nous pouvons continuer de renforcer le programme pour nous assurer qu'il demeure pertinent pour vous et vos services.

Au plaisir de continuer à travailler en partenariat avec vous.

Wendy Nicklin

Wendy Nicklin
Présidente-directrice générale

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Section 1 Sommaire

Agrément Canada est un organisme indépendant sans but lucratif qui établit des normes pour assurer la qualité et la sécurité des soins de santé et qui procède à l'agrément d'organismes de santé au Canada et dans le monde entier. Les organismes agréés par Agrément Canada sont soumis à un processus d'évaluation rigoureux. Après qu'une auto-évaluation ait été effectuée en profondeur, des visiteurs formés à cet effet et qui proviennent d'organismes de santé agréés vont mener une visite dans l'organisme pour en évaluer le rendement par rapport aux normes d'excellence d'Agrément Canada.

Hôpital Sainte-Anne (nommé «l'organisme» dans le présent rapport) participe au programme Qmentum d'Agrément Canada. Ce rapport d'agrément fait état des résultats à ce jour et est fourni dans le but de guider l'organisme dans sa volonté d'intégrer les principes de l'agrément et de l'amélioration de la qualité à ses programmes, à ses politiques et à ses pratiques.

Il convient de féliciter l'organisme suivant : Hôpital Sainte-Anne pour son engagement à se servir de l'agrément pour améliorer la qualité et la sécurité des services qu'il offre à ses clients et à sa communauté.

1.1 Décision relative au type d'agrément décerné

Hôpital Sainte-Anne a obtenu le type d'agrément qui suit.

TYPE D'AGRÉMENT DÉCERNÉ
Agrément avec condition

Section 1 Sommaire

1.2 Au sujet de la visite d'agrément

- **Dates de la visite : 6 au 9 septembre 2011**

- **Lieu**

L'emplacement suivant a été évalué pendant la visite d'agrément.

1 Hôpital Sainte Anne

- **Normes**

Les sections de normes suivantes ont été utilisées pour évaluer les programmes et services de l'organisme pendant la visite d'agrément.

Normes relatives à l'ensemble de l'organisme

1 Efficacité organisationnelle

Normes sur l'excellence des services

2 Normes de gestion des médicaments
3 Prévention des infections
4 Soins ambulatoires
5 Services de laboratoires biomédicaux
6 Normes d'imagerie diagnostique
7 Laboratoires et banques de sang
8 Services de soins de longue durée
9 Banques de sang et services transfusionnels

- **Mesures de rendement**

L'organisme a transmis des données relatives aux mesures de rendement qui suivent.

Outils

1 Sondage sur la culture de sécurité des patients
2 Sondage Pulse sur la qualité de vie au travail

Section 1 Sommaire

1.3 Analyse selon les dimensions de la qualité

Agrément Canada définit la qualité des soins de santé à l'aide de huit dimensions de la qualité qui représentent les principaux éléments de la prestation des services.

Chaque critère des normes est lié à une dimension de la qualité. Ce tableau énumère les dimensions de la qualité et illustre combien des critères qui se rapportent à chacune d'entre elles ont été cotés conformes, non conformes ou sans objet pendant la visite d'agrément.

Dimension de la qualité	Conformité	Non-conformité	S.O.	Total
Accent sur la population (Travailler avec les collectivités pour prévoir les besoins et y répondre.)	23	1	1	25
Accessibilité (Offrir des services équitables, en temps opportun.)	47	1	2	50
Sécurité (Assurer la sécurité des gens.)	236	14	112	362
Milieu de travail (Favoriser le bien-être en milieu de travail.)	51	1	3	55
Services centrés sur le client (Penser d'abord aux clients et aux familles.)	56	2	11	69
Continuité des services (Offrir des services coordonnés et non interrompus.)	16	0	2	18
Efficacité (Faire ce qu'il faut pour atteindre les meilleurs résultats possibles.)	340	34	91	465
Efficience (Utiliser les ressources le plus adéquatement possible.)	33	3	3	39
Total	802	56	225	1083

Section 1 Sommaire

1.4 Analyse selon les sections de normes

Les normes d'excellence du programme Qmentum permettent de cerner les politiques et les pratiques qui contribuent à fournir des soins sécuritaires et de haute qualité qui sont gérés efficacement. Chaque norme est accompagnée de critères qui contribuent à atteindre le but visé par la norme.

Les normes relatives à l'ensemble de l'organisme portent sur la qualité et la sécurité à l'échelle de l'organisme dans des secteurs comme la gouvernance et la direction, tandis que les normes portant sur des populations spécifiques et sur l'excellence des services traitent de clientèles, de secteurs et de services bien précis. Les sections de normes qui servent à évaluer les programmes d'un organisme sont choisies en fonction du type de services offerts.

Ce tableau fait état des sections de normes qui ont servi à évaluer les programmes et services de l'organisme, ainsi que du nombre et du pourcentage de critères pour lesquels il y a conformité ou non-conformité et ceux qui sont cotés sans objet.

Sections de normes	Critères à priorité élevée			Autres critères			Tous les critères (Priorité élevée + autres)		
	Conformité	Non-conformité	S.O.	Conformité	Non-conformité	S.O.	Conformité	Non-conformité	S.O.
	Nbre (%)	Nbre (%)	Nbre	Nbre (%)	Nbre (%)	Nbre	Nbre (%)	Nbre (%)	Nbre
Normes relatives à l'ensemble de l'organisme									
Efficacité organisationnelle	50(89%)	6(11%)	1	46(96%)	2(4%)	1	96(92%)	8(8%)	2
Normes sur l'excellence des services									
Prévention des infections	42(98%)	1(2%)	14	37(95%)	2(5%)	7	79(96%)	3(4%)	21
Banques de sang et services transfusionnels	27(100%)	0(0%)	85	14(100%)	0(0%)	38	41(100%)	0(0%)	123
Laboratoires et banques de sang	65(92%)	6(8%)	10	71(88%)	10(12%)	14	136(89%)	16(11%)	24
Normes d'imagerie diagnostique	39(91%)	4(9%)	9	46(96%)	2(4%)	5	85(93%)	6(7%)	14
Normes de gestion des médicaments	69(95%)	4(5%)	10	45(90%)	5(10%)	2	114(93%)	9(7%)	12

Section 1 Sommaire

Sections de normes	Critères à priorité élevée			Autres critères			Tous les critères (Priorité élevée + autres)		
	Conformité	Non-conformité	S.O.	Conformité	Non-conformité	S.O.	Conformité	Non-conformité	S.O.
	Nbre (%)	Nbre (%)	Nbre	Nbre (%)	Nbre (%)	Nbre	Nbre (%)	Nbre (%)	Nbre
Normes sur l'excellence des services									
Services de laboratoires biomédicaux	10(63%)	6(38%)	0	31(86%)	5(14%)	0	41(79%)	11(21%)	0
Services de soins de longue durée	38(97%)	1(3%)	0	80(99%)	1(1%)	1	118(98%)	2(2%)	1
Soins ambulatoires	30(97%)	1(3%)	14	62(100%)	0(0%)	14	92(99%)	1(1%)	28
Total	370(93%)	29(7%)	143	432(94%)	27(6%)	82	802(93%)	56(7%)	225

Section 1 Sommaire

1.5 Aperçu par pratiques organisationnelles requises

Dans le programme Qmentum, une pratique organisationnelle requise (POR) se définit comme étant une pratique essentielle qui doit être en place dans l'organisme pour améliorer la sécurité des clients et pour minimiser les risques. Chaque POR comporte des tests de conformité, et il faut répondre aux exigences de tous les tests pour être jugé conforme à la POR.

Ce tableau fait état des POR et de la cote attribuée à chacune pendant la visite.

Pratique organisationnelle requise	Cote
But en matière de sécurité des patients : Culture de sécurité	
Analyse prospective liée à la sécurité des patients	Conformité
Déclaration des événements indésirables	Conformité
Mécanisme de déclaration des événements indésirables	Conformité
Rapports trimestriels sur la sécurité des patients	Conformité
Sécurité des patients sous forme de priorité stratégique	Conformité
But en matière de sécurité des patients : Communication	
Abréviations dangereuses	Conformité
Bilan comparatif des médicaments à l'admission	Conformité
Bilan comparatif des médicaments au transfert ou au congé	Non-conformité
Bilan comparatif des médicaments en tant que priorité organisationnelle	Non-conformité
Deux identificateurs de client	Conformité
Processus de vérification des activités liées aux soins et services à risques élevés	Conformité
Rôle des clients et des familles en ce qui concerne la sécurité	Non-conformité
Transfert de l'information	Conformité

Section 1 Sommaire

Pratique organisationnelle requise	Cote
But en matière de sécurité des patients : Utilisation des médicaments	
Concentrations de médicaments	Conformité
Électrolytes concentrés	Conformité
Formation sur les pompes à perfusion	Conformité
Sécurité liée à l'héparine	Conformité
Sécurité liée aux narcotiques	Conformité
But en matière de sécurité des patients : Milieu de travail	
Plan de sécurité des patients	Conformité
Prévention de la violence en milieu de travail	Conformité
Programme d'entretien préventif	Conformité
Sécurité des patients : formation et perfectionnement	Conformité
Sécurité des patients : rôles et responsabilités	Conformité
But en matière de sécurité des patients : Prévention des infections	
Directives sur la prévention des infections	Conformité
Formation et perfectionnement sur l'hygiène des mains	Conformité
Processus de stérilisation	Conformité
Taux d'infection	Conformité
Vaccin antigrippal	Conformité
Vaccin antipneumococcique	Conformité
Vérification de l'hygiène des mains	Conformité
But en matière de sécurité des patients : Prévention des chutes	
Stratégie de prévention des chutes	Conformité
But en matière de sécurité des patients : Évaluation des risques	
Prévention des plaies de pression	Conformité

Section 1 Sommaire

1.6 Sommaire des constatations de l'équipe des visiteurs

Pendant la visite d'agrément, l'équipe de visiteurs a fait les observations suivantes au sujet de l'ensemble des points forts, des possibilités d'amélioration et des défis de l'organisme.

Une équipe de direction engagée et compétente assure un fort leadership et veille au maintien de hauts standards de qualité de soins et de services, dans un contexte d'incertitude et de transition associé au projet de transfert de l'établissement vers une autorité provinciale. Le processus officiel de négociation est débuté depuis 2011 et les dirigeants sont félicités pour la planification de ce changement de gouvernance. On note un plan de communication structuré auprès des divers publics dans un souci de transparence, veillant à préserver la qualité des soins et services aux anciens combattants, et les intérêts du personnel de l'organisme.

L'équipe de direction a insufflé depuis des années, une culture de l'excellence et d'amélioration continue de la qualité, par l'adoption de pratiques rigoureuses d'évaluation et de rétroaction dans ses secteurs cliniques, administratifs et de soutien. L'équipe de direction démontre son engagement et son soutien important à la réalisation de projets de recherche reliés aux soins et pour lesquels l'organisme s'associe à divers organismes de recherche.

L'organisme maintient d'excellentes relations de partenariat avec l'Université McGill et les chercheurs de cette institution. L'équipe de dirigeants est encouragée à développer davantage ce lien de partenariat avec ses programmes cliniques, ainsi qu'avec d'autres organisations de vétérans à l'extérieur du pays. Les partenaires consultés ont exprimé un haut taux de satisfaction en regard des liens existants entre l'Hôpital Sainte-Anne et ceux-ci. L'organisme accueille plusieurs membres des Légions dans les communautés avoisinantes qui s'impliquent entre autre, comme bénévoles.

On note un Programme de reconnaissance des employés qui inclut une variété de mesures visant à souligner l'excellence des contributions. L'organisme est félicité pour son Plan intégré des ressources humaines 2010-2013 qui fait état des stratégies prévues et en cours de réalisation pour diriger l'organisme dans ses défis en matière de ressources humaines. Cet outil permet judicieusement de soutenir les orientations stratégiques de l'Hôpital Sainte-Anne dont le volet dotation pour tous les postes dans l'organisation incluant un plan de relève. Tous les employés rencontrés parlent favorablement du climat de travail et ils sont très fiers d'appartenir à l'organisation. Le taux de rétention est très élevé et exceptionnel. L'organisme est félicité pour les diverses opportunités qu'elle rend accessible aux employés afin de répondre à leurs besoins d'un meilleur équilibre vie-travail, favoriser une meilleure intégration à l'emploi et valoriser les individus. Les statistiques démontrent un accroissement du nombre d'employés se prévalant de mesures d'adaptation toutes diversifiées et intéressantes.

La prestation des soins et services est centrée sur le client et il y a un constant souci d'adapter les services aux besoins de la clientèle. Plusieurs programmes cliniques sont développés et appliqués, on procède également à leur évaluation continue dans le temps. L'établissement dispose de ressources lui permettant d'innover et de stimuler le développement d'idées nouvelles pour améliorer continuellement les soins, les services et le milieu de vie.

L'organisme a complété un extraordinaire projet de 114 millions $ sur une période de 9 ans, pour la réfection complète des unités de vie et des espaces extérieurs qui intègrent, tous les principes d'un aménagement thérapeutique et sécuritaire adapté à sa clientèle. L'organisme est félicité pour s'être mérité des prix d'excellence, pour les caractéristiques exceptionnelles de ses nouveaux édifices en terme d'économie d'énergie, de confort et d'efficience.

Section 1 Sommaire

Les principes de sécurité des patients sont intégrés dans toutes les activités de la vie quotidienne et dans le comportement des employés. Plusieurs équipements et des systèmes d'alarme sécuritaires et adéquats sont utilisés pour la sécurité des résidents mais également pour atteindre d'exceptionnels résultats en matière d'utilisation de contention (3,2 %).

Les sondages complétés par la clientèle, le comité des usagers et les résidents rencontrés ont tous exprimé des éloges et un haut niveau de satisfaction relativement aux soins, aux services, à leur milieu de vie et à l'écoute, l'attention et l'attitude chaleureuse du personnel. Ils formulent par ailleurs des inquiétudes quant à la possibilité de perdre ces éléments conséquemment à un transfert à une autorité provinciale.

Section 2 Résultats détaillés relatifs aux pratiques organisationnelles requises

Cette section fournit plus d'information au sujet des POR pour lesquelles il n'y a pas conformité. On y illustre les buts liés à la sécurité des patients sous lesquels sont regroupées les POR, les exigences entourant les POR, et les sections de normes où elles se trouvent.

Les buts en matière de sécurité des patients sont les suivants : culture de sécurité, communication, utilisation des médicaments, milieu de travail et effectifs, prévention des infections, et évaluation des risques.

Pratiques organisationnelles requises pour lesquelles il n'y a pas conformité	Sections de normes
But en matière de sécurité des patients : Communication	
Rôle des clients et des familles en ce qui concerne la sécurité L'équipe informe et forme les clients et les familles au sujet de leur rôle en ce qui concerne la sécurité par le biais de communications écrites et verbales.	· Soins ambulatoires 17.4
Bilan comparatif des médicaments au transfert ou au congé L'équipe établit le bilan comparatif des médicaments du client de concert avec le client, la famille ou le soignant aux points de transition lorsque les ordonnances de médicaments sont changées ou réécrites (c.-à-d., au moment d'un transfert à l'interne ou du congé).	· Services de soins de longue durée 12.3
Bilan comparatif des médicaments en tant que priorité organisationnelle L'organisme établit le bilan comparatif des médicaments des clients à l'admission, ainsi qu'au moment du transfert ou du congé.	· Efficacité organisationnelle 6.6

Section 3 Résultats détaillés de la visite

Agrément Canada définit les processus prioritaires comme des secteurs critiques et des mécanismes qui ont des répercussions importantes sur la qualité et la sécurité des soins et services. Les processus prioritaires offrent un point de vue différent de celui que fournissent les normes, car les résultats sont organisés en fonction de thèmes qui se recoupent dans l'ensemble des unités, des services et des équipes.

Par exemple, le processus prioritaire qui traite du cheminement des clients porte sur des critères provenant de plusieurs sections de normes qui touchent chacune à divers aspects du cheminement des clients, de la prévention des infections à l'établissement d'un diagnostic ou à la prestation de services chirurgicaux au moment opportun. Cela offre une image complète de la façon dont les patients sont acheminés dans l'organisme et de la façon dont les services leur sont offerts, et ce, peu importe l'unité ou le service.

Au cours de la visite d'agrément, les visiteurs évaluent la conformité aux critères, expliquent ce qui justifie la cote attribuée et émettent des commentaires sur chaque processus prioritaire.

Ce rapport contient des commentaires relatifs aux processus prioritaires. Les explications qui justifient la cote de non-conformité attribuée à certains critères se trouvent dans le plan d'amélioration de la qualité du rendement dans le portail de l'organisme.

Se reporter à l'annexe B pour une liste des processus prioritaires.

Interprétation des tableaux : Les tableaux font état de tous les critères où il n'y a pas conformité dans chacune des sections de normes, précisent lesquels ont un niveau de priorité élevé, et fournissent les commentaires des visiteurs pour chaque processus prioritaire. Les critères à priorité élevée sont identifiés au moyen des symboles suivants :

Critère à priorité élevée

Pratique organisationnelle requise

3.1 Résultats pour les normes relatives à l'ensemble de l'organisme, par processus prioritaires

Les résultats qui se trouvent dans cette section sont d'abord divisés en fonction des processus prioritaires, puis en fonction des sections de normes.

Certains processus prioritaires de cette section s'appliquent aussi aux normes sur l'excellence des services. Si des critères où il y a non-conformité sont aussi liés aux services, les résultats devraient être transmis à l'équipe concernée.

Section 3 Résultats détaillés de la visite

3.1.1 Processus prioritaire : Planification et conception des services

Élaborer et mettre en œuvre l'infrastructure, les programmes et les services nécessaires pour répondre aux besoins des populations et des communautés desservies.

Critère non respecté		Critères à priorité élevée
Sections de normes : Efficacité organisationnelle		
5.3	Les dirigeants de l'organisme élaborent et mettent en oeuvre un cadre conceptuel en matière d'éthique qui est adopté par le conseil d'administration, s'il y a lieu.	!

Commentaires des visiteurs pour ce(s) processus prioritaire(s)

L'organisme dispose de sources d'informations diversifiées, autant internes qu'externes, lui permettant de connaître les besoins de sa population : les anciens combattants. Les dirigeants utilisent judicieusement cette information et la diffuse aux équipes afin de développer, réviser et améliorer de façon continue les soins et services à la clientèle.

Les dirigeants sont félicités pour la démarche d'élaboration des plans d'action annuels et des propositions évocatrices 2011-2012 qui découlent du plan stratégique 2008-2011 et qui soutiennent la réalisation de sa mission et de sa vision. Une large consultation des partenaires internes, externes dont les employés, médecins et bénévoles rassemble les forces vives de l'organisme et les personnes rencontrées témoignent une haute appréciation et un engagement fort envers leurs équipes et l'organisme.

L'énoncé des valeurs a fait l'objet d'une révision, auxquelles ont été associés de façon dynamique, les partenaires internes. Les divers échanges et rencontres tenues avec le personnel lors de la visite confirment l'intégration des valeurs dans les comportements et la prise de décision au sein de l'organisation. On constate que les valeurs affichées sont également celles appliquées.

Le Comité de l'équipe de direction s'assure également que les questions éthiques sont traitées avec compétence par les instances et personnes désignées. Les préoccupations manifestes de l'organisme à l'égard de l'éthique dans la gestion, la décision, l'éthique clinique et de la recherche, devraient être intégrées dans un cadre conceptuel en matière d'éthique.

Il faut souligner l'excellence, la pertinence et l'implantation de nombreux programmes cliniques appliqués auprès de la clientèle : programme de santé bucco-dentaire, programme douleur, programme MPOC, programme clinique TSO (traumatisme de stress opérationnel), soins des plaies, prévention des chutes, soins buccaux et autres. L'organisme s'inspire des résultats probants de la recherche et de bonnes pratiques recensées dans la littérature et applique la démarche PIER (Planification, implantation, évaluation et rétroaction) lorsqu'elle met en place des programmes à l'échelle de l'organisation. Cette démarche est rigoureusement appliquée et permet l'évaluation d'impact et des résultats des divers programmes, le tout dans une perspective d'amélioration continue de la qualité des soins et des services.

Les dirigeants de l'organisme sont au carrefour d'une démarche impliquant les paliers de gouvernement fédéral et provincial, pour le transfert vers une autorité provinciale, de la responsabilité et du rattachement

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administratif de l'établissement. Puisqu'aucune décision n'a été prise actuellement, on note particulièrement chez la clientèle, de l'inquiétude face à la qualité des soins dans l'avenir. Les dirigeants démontrent un souci constant et une volonté à travailler avec les représentants ministériels et les gouvernements, à la recherche d'une solution qui permettra à l'organisme et ses équipes, de mettre à profit au sein du réseau de la santé (québécois et canadien), les pratiques cliniques d'excellence et les pratiques de gestion qui ont été développées, implantées et qui produisent des résultats positifs au sein de l'organisme.

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3.1.2 Processus prioritaire : Gestion des ressources

Surveiller, administrer et intégrer les activités touchant l'allocation et l'utilisation des ressources.

L'organisme s'est conformé à tous les critères pour ce processus prioritaire.

Commentaires des visiteurs pour ce(s) processus prioritaire(s)

L'organisme s'inscrit dans un cycle budgétaire bien établi et balisé par des politiques, des directives et des orientations budgétaires émanant principalement de l'autorité gouvernementale. Une démarche structurée permet aux dirigeants de prendre des décisions en équipe, quant à l'allocation annuelle des ressources et l'évaluation des projets de développement. Une relation de partenariat constructive entre les dirigeants, le personnel et la Fondation de l'hôpital permet à ces derniers de participer efficacement au développement de la qualité des services à la clientèle. D'excellents projets ont été réalisés au fil des années.

Malgré les contraintes financières qui sont imposées à l'organisme pour l'année en cours, l'équilibre budgétaire est atteint grâce à un suivi attentif exercé aux divers paliers de gestion.

Une formation offerte aux nouveaux gestionnaires leur permet de développer des compétences dans la gestion financière. Plusieurs mentionnent le problème lié aux logiciels des systèmes financiers qui ne sont pas interfacés avec les systèmes de paie et de gestion de ressources humaines. Compte tenu de la difficulté de produire des rapports intégrant toute l'information financière, l'analyse de l'utilisation des ressources repose sur des outils personnalisés que se développent les gestionnaires. Ce mécanisme compensatoire n'est pas optimal mais il permet aux dirigeants et gestionnaires d'assumer adéquatement leurs responsabilités.

Le cycle annuel de priorisation des projets d'immobilisation et d'acquisition d'équipements est connu et met à contribution les gestionnaires et les équipes des différents services. Des critères permettent de prioriser les acquisitions cependant, on note une gamme parfois variée d'équipements de même type. Les dirigeants sont invités à évaluer cette situation qui n'est pas optimale pour le personnel utilisateur qui doit composer avec des modèles différents. Cette situation pourrait être une source d'erreur et a également des impacts pour les équipes chargées de l'entretien préventif et des réparations.

Section 3 Résultats détaillés de la visite

3.1.3 Processus prioritaire : Capital humain

Renforcement de la capacité des ressources humaines à fournir des services sécuritaires et de grande qualité.

L'organisme s'est conformé à tous les critères pour ce processus prioritaire.

Commentaires des visiteurs pour ce(s) processus prioritaire(s)

Un Plan intégré des ressources humaines 2010-2013 fait état des stratégies prévues et en cours de réalisation pour diriger l'organisme dans ses défis en matière de ressources humaines. Cet outil permet judicieusement de soutenir les orientations stratégiques de l'Hôpital Sainte-Anne et l'équipe de la direction des ressources humaines ainsi que ses partenaires sont félicités pour leur excellent travail à cet égard.

En lien avec le projet de transfert de l'organisme vers une autorité provinciale, le personnel manifeste son appréciation des stratégies d'information qui sont mises en place et la direction est invitée à maintenir l'intensité et la diversité de ses communications avec les employés. Il persiste chez les employés, des inquiétudes à des degrés variables face à un avenir encore inconnu toutefois, on reconnaît que le pouvoir de décision implique des instances externes à l'organisation.

L'organisme est félicité pour les diverses opportunités qu'elle rend accessibles aux employés afin de répondre à leurs besoins d'un meilleur équilibre vie-travail, de favoriser une meilleure intégration à l'emploi et la valorisation des individus. Les statistiques démontrent un accroissement du nombre d'employés se prévalant de mesures d'adaptation toutes diversifiées et intéressantes.

En plus du Sondage Pulse, l'organisme administre aux trois ans (2008 et 2011) le Sondage auprès des fonctionnaires fédéraux, duquel un plan d'action est élaboré en vue d'améliorer le leadership, l'effectif et les conditions de travail. Les stratégies mises de l'avant issues des résultats de ces sondages, potentialisent les effets positifs sur le milieu de travail. Les dirigeants et le personnel sont félicités pour leur dynamisme et leur engagement à l'amélioration de leur milieu de travail.

La démarche annuelle d'appréciation du rendement de tous les employés, implique un processus d'autoévaluation et l'identification d'objectifs pour chaque employé. Cette démarche est mobilisante et on y rattache des cibles de développement des compétences, le tout bien intégré et suivi en cours d'année, dans le plan d'apprentissage de l'employé. Félicitation pour cette pratique qui s'ajoute au Programme de reconnaissance des employés, déjà bien implanté. L'équipe des gestionnaires est encouragée dans son objectif d'élargir la reconnaissance au quotidien des employés, à travers des relations supérieurs-employés empreintes de témoignages d'appréciation.

La révision de toutes les descriptions de fonctions de l'hôpital est en voie de parachèvement et leur contenu énonce les comportements attendus en lien avec la sécurité des patients. Le programme d'orientation des nouveaux employés : Bienvenue à bord ! est structuré et pertinent, une part importante du contenu réfère à la sécurité des patients. Une intéressante documentation d'appoint remise à l'employé lui permet d'être informé des aspects importants pour la réussite dans son travail.

Le service des bénévoles est bien structuré et un guide d'orientation est disponible pour l'intégration des personnes bénévoles dans le milieu. Leur implication est diversifiée auprès des résidents et leur famille, leur présence est continue sur 7 jours ce qui est apprécié des équipes. Félicitation aux personnes bénévoles pour leur implication.

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3.1.4 Processus prioritaire : Gestion intégrée de la qualité

Avoir recours à un processus proactif, systématique et continu pour gérer et intégrer la qualité, et pour atteindre les buts et les objectifs de l'organisme.

Critère non respecté	Critères à priorité élevée
Sections de normes : Efficacité organisationnelle	
6.6 L'organisme établit le bilan comparatif des médicaments des clients à l'admission, ainsi qu'au moment du transfert ou du congé.	POR
6.6.2 L'établissement du bilan comparatif des médicaments est instauré dans un secteur de prestation de services au moment du transfert ou du congé.	

Commentaires des visiteurs pour ce(s) processus prioritaire(s)

L'organisme a clairement adopté la sécurité des patients par écrit et cet objectif est maintenu comme étant une priorité constante. Le comité des usagers confirme les efforts déployés par les équipes soignantes dans le domaine de la sécurité et il est très conscient de la gestion intégrée de la qualité dans tout l'établissement.

Certains membres du comité des usagers expriment des inquiétudes quant au transfert éventuel de l'organisme du Gouvernement fédéral au Gouvernement provincial et ils craignent une détérioration de la qualité des soins et des services auxquels ils sont habitués. Le président de ce comité rassure toutefois ses membres des préoccupations strictes de la direction pour garantir la priorité des soins aux vétérans lors d'un transfert éventuel et il est confiant qu'un transfert permettra de poursuivre la mission de l'établissement et le maintien du niveau de qualité des soins et des services actuels.

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3.1.5 Processus prioritaire : Prestation de soins et prise de décisions fondées sur des principes

Cerner les dilemmes et les problèmes relatifs à l'éthique et prendre les décisions qui s'imposent.

Critère non respecté	Critères à priorité élevée
Sections de normes : Efficacité organisationnelle	
5.4 Le cadre conceptuel en matière d'éthique définit les processus officiels pour faire face aux problèmes et aux préoccupations liés à l'éthique.	!
5.5 Le cadre conceptuel en matière d'éthique englobe un processus pour examiner les répercussions de la recherche sur l'éthique.	!

Commentaires des visiteurs pour ce(s) processus prioritaire(s)

Il n'existe pas de cadre conceptuel en matière d'éthique. Toutefois, il existe un comité éthique et le personnel connaît bien les mécanismes pour faire appel à ce comité. De plus, des mécanismes de transfert de l'information sur les résultats des discussions éthiques sont diffusés au personnel et fort appréciés par eux. Bien qu'un cadre conceptuel est inexistant, des formations et des démarches démontrent la préoccupation de la direction d'intégrer au quotidien les valeurs liées au code d'éthique. L'organisme s'appuie sur le code de valeurs et d'éthique de la fonction publique. L'établissement est invité à rédiger un cadre conceptuel en matière d'éthique et à mettre à jour le document du comité éthique qui date d'avril 2005.

Le programme de contention s'est développé à partir d'un problème éthique soulevé par le personnel. Par la suite, le programme s'est mis en place progressivement dans chacune des unités.

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3.1.6 Processus prioritaire : Communication

Assurer une communication efficace à tous les paliers de l'organisme et avec les partenaires de l'externe.

Critère non respecté	Critères à priorité élevée
Sections de normes : Efficacité organisationnelle	
3.4 Les dirigeants de l'organisme consultent ses partenaires pour évaluer l'efficacité de ses relations avec ceux-ci.	

Commentaires des visiteurs pour ce(s) processus prioritaire(s)

L'établissement identifie les partenaires externes et se situe dans un esprit de collaboration et d'entraide avec eux. Les partenaires consultés ont exprimé un haut taux de satisfaction en regard des liens existants entre l'hôpital Sainte-Anne et ceux-ci. Par ailleurs, les dirigeants de l'établissement sont invités à s'assurer que les liens avec les partenaires où la clientèle est acheminée permettent une communication plus efficace lors du retour du client.

Le comité de direction a mis en place un mécanisme de transmission d'informations et de rétroaction appelée communication "Face à face" appréciée par des membres du personnel rencontré. D'autres ont soulevé l'inégalité de cette transmission d'information. De plus, l'établissement a mené un sondage de satisfaction des employés sur les outils de communication de l'hôpital Sainte-Anne selon un échantillon représentant les départements et les quarts de travail, en avril 2009. Les résultats du sondage ont été analysés et des modifications ont été apportées. Malgré le souci et le travail constant du comité de direction à ce niveau, l'établissement est invité à continuer à parfaire ses mécanismes de communication.

La direction a produit un lexique des abréviations cliniques révisé en juillet 2010. De plus, un audit a été fait sur les abréviations dangereuses datant de mars 2011. Des affiches en français et en anglais ont été produites et affichées.

Les systèmes d'information de gestion ne sont pas intégrés et ne permettent pas de produire des rapports pour soutenir la prise de décision. Pour pallier à cette problématique, l'organisme a créé des outils personnalisés ce qui demande temps et énergie. Toutefois, le contexte actuel d'un possible transfert du fédéral au provincial peut expliquer les délais à apporter les correctifs actuellement.

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3.1.7 Processus prioritaire : Environnement physique

Fournir des structures et des établissements appropriés et sécuritaires pour réaliser la mission, la vision et les buts de l'organisme.

L'organisme s'est conformé à tous les critères pour ce processus prioritaire.

Commentaires des visiteurs pour ce(s) processus prioritaire(s)

L'environnement physique de l'organisme est conforme aux lois, règlements et codes du Gouvernement fédéral et à celles du ministère des Anciens combattants. Les locaux sont propres et bien entretenus et le personnel du secteur de la salubrité travaille en collaboration étroite avec le personnel des unités de soins et les responsables de la prévention des infections.

D'importants travaux de modernisation au coût de 114M$ ont été récemment réalisés sur une période de neuf ans et ont impliqué des mesures strictes de protection pour les résidents et le personnel. Ces travaux ont aussi impliqué les responsables de la prévention des infections. Ces travaux ont également permis l'installation d'un système de géothermie et de plusieurs éléments technologiques qui ont valu des prix de prestige à l'organisme et à leurs concepteurs.

Outre les équipements modernes de détection et de lutte contre les incendies, l'organisme peut compter sur une brigade d'incendie de quelque 32 bénévoles recrutés au sein de ses équipes soignantes pour une couverture permanente sur place.

L'organisme a adopté une gestion environnementale en conformité avec la Stratégie fédérale de développement durable 2011 et un comité environnement et développement durable est en place pour promouvoir les acquisitions écologiques, la gestion des matières résiduelles, la gestion de l'eau, la gestion de l'énergie, les transports et la gestion des sols. Ces initiatives ont valu à l'organisme plusieurs prix de reconnaissance.

Section 3 Résultats détaillés de la visite

3.1.8 Processus prioritaire : Préparation en vue de situations d'urgence

Gérer les urgences, les sinistres ou autres aspects relevant de la sécurité publique, et planifier en ce sens.

Critère non respecté	Critères à priorité élevée
Sections de normes : Efficacité organisationnelle	
11.8 Les dirigeants de l'organisme mettent régulièrement à l'essai les plans de l'organisme en vue de sinistres ou d'urgences en effectuant des exercices.	!

Commentaires des visiteurs pour ce(s) processus prioritaire(s)

Les plans de mesures d'urgence de l'organisme sont structurés et intégrés au sein des différentes équipes d'intervention et des partenaires. La mise à jour régulière de ces plans est assurée. L'organisme est doté d'un comité des mesures d'urgence qui assure le suivi et une intégration optimale des plans. Des exercices d'évacuation annuels sont complétés et analysés afin d'identifier des pistes d'amélioration et d'augmenter la performance. L'organisme offre une formation annuelle sur plusieurs volets des plans de mesures d'urgence.

Section 3 Résultats détaillés de la visite

3.1.9 Processus prioritaire : Cheminement des clients

Évaluation du déplacement sans heurt et en temps opportun des clients et des familles entre les services et les milieux de soins.

L'organisme s'est conformé à tous les critères pour ce processus prioritaire.

Commentaires des visiteurs pour ce(s) processus prioritaire(s)

Le personnel et les équipements à l'imagerie médicale répondent adéquatement aux besoins de la clientèle de l'établissement.

Lors du transfert d'un client en soins de longue durée, des mécanismes formels à l'admission pour bien intégrer la personne sont appliqués. Selon l'évaluation, des informations sont immédiatement transmises à l'unité de soins s'il y a détection de problèmes de sécurité. Afin d'informer la famille de l'intégration du nouveau résident, des suivis sont faits par les intervenants auprès de la famille, dès les premiers jours.

L'établissement a produit une politique et des procédures lors d'un transfert à l'interne d'un résident. Des mécanismes de transfert sont bien implantés et appliqués par les membres du personnel afin d'assurer le succès du transfert. Une échelle d'identification des risques de relogement a été formalisée et appliquée chez tous les clients qui sont relocalisés et des suivis sont faits pour en apprécier les résultats.

Section 3 Résultats détaillés de la visite

3.1.10 Processus prioritaire : Équipement et appareils médicaux

Obtenir et entretenir du matériel et des technologies qui servent au diagnostic et au traitement de problèmes de santé.

Critère non respecté		Critères à priorité élevée
Sections de normes : Efficacité organisationnelle		
10.4	Les dirigeants de l'organisme suivent un plan d'entretien, de modernisation et de remplacement de l'équipement, des appareils ou instruments médicaux.	
10.6	Les dirigeants de l'organisme suivent les politiques et procédures pour la gestion des incidents impliquant l'équipement, la technologie et les appareils ou instruments médicaux, y compris les événements indésirables ou les cas de mauvaise utilisation.	!

Commentaires des visiteurs pour ce(s) processus prioritaire(s)

Les équipements et appareils médicaux en usage dans l'organisme sont généralement en bon état et appropriés à la clientèle de soins de longue durée. Les dirigeants de l'organisme devraient cependant disposer d'un processus structuré et transparent unique pour sélectionner et acheter l'équipement, les instruments et les appareils médicaux, ainsi que pour choisir les fournisseurs.

Les dirigeants de l'organisme devraient disposer d'un plan formalisé d'entretien, de modernisation et de remplacement de l'équipement, des équipements ou appareils médicaux.

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3.2 Résultats pour les normes sur l'excellence des services

Les résultats qui se trouvent dans cette section sont d'abord divisés en fonction des sections de normes, puis des processus prioritaires.

Les processus prioritaires propres aux normes sur l'excellence des services sont les suivants :

Direction clinique

- Diriger et guider les équipes qui offrent les services.

Compétences

- Créer une équipe interdisciplinaire dotée des connaissances et du savoir-faire nécessaires pour gérer et offrir des programmes et des services efficaces.

Épisode de soins

- Offrir des services de santé coordonnés aux clients à partir du premier contact avec un prestateur de soins jusqu'à la dernière rencontre liée à leur problème de santé.

Aide à la décision

- Se servir de l'information, de la recherche, des données et de la technologie pour appuyer la gestion et la prise de décisions d'ordre clinique.

Impact sur les résultats

- Cerner et assurer le suivi des mesures de processus et de résultats pour évaluer et améliorer la qualité des services et les résultats des clients.

Gestion des médicaments

- Avoir recours à des équipes interdisciplinaires pour gérer la prestation des services de pharmacie.

Prévention des infections

- Instaurer des mesures pour prévenir et réduire l'acquisition et la transmission d'infections chez le personnel, les prestateurs de services, les clients et les familles.

Services de diagnostic - Imagerie

- Assurer la disponibilité de services d'imagerie diagnostique pour aider les professionnels de la santé à établir un diagnostic pour leurs clients et à surveiller leurs problèmes de santé.

Services de diagnostic - Laboratoire

- Assurer la disponibilité de services de laboratoire pour aider les professionnels de la santé à établir un diagnostic pour leurs clients et à surveiller leurs problèmes de santé.

Banques de sang et services transfusionnels

- Manipulation sécuritaire du sang et des produits sanguins labiles, ce qui englobe la sélection du donneur, le prélèvement sanguin et la transfusion.

Section 3 Résultats détaillés de la visite

3.2.1 Sections de normes : Banques de sang et services transfusionnels

Critère non respecté	Critères à priorité élevée
Processus prioritaire : Banques de sang et services transfusionnels	
L'organisme s'est conformé à tous les critères pour ce processus prioritaire.	

Commentaires des visiteurs pour ce(s) processus prioritaire(s)

Processus prioritaire : Banques de sang et services transfusionnels

Les services de banque de sang et services transfusionnels sont couverts de façon efficace et respectent les règles exigées par Héma-Québec. La coordonnatrice du laboratoire assiste aux réunions du comité transfusionnel de façon ponctuelle.

Les procédures pour l'administration des produits sanguins sont bien documentées et appliquées par les membres du personnel infirmier. Les notes au dossier du receveur sont rédigées clairement et une étiquette affichant le numéro de lot du culot ou du produit reçu est apposé avec les notes au dossier concernant le receveur.

Un dossier des transfusions reçues est tenu rigoureusement au laboratoire pour chacun des patients receveurs et contient toutes les informations pertinentes permettant la traçabilité.

Section 3 Résultats détaillés de la visite

3.2.2 Sections de normes : Laboratoires et banques de sang

Critère non respecté		Critères à priorité élevée
Processus prioritaire : Services de diagnostic - Laboratoire		
1.1	Au moins une fois par année, le laboratoire recueille et revoit l'information concernant les volumes des services, le point de vue des clients au sujet des services, les tendances parmi les requêtes provenant des prestateurs de services, et d'autres organismes. Référence ISO : 15189-07, 4.1.2	
1.3	Le laboratoire tient compte des connaissances actuelles concernant les meilleures pratiques et des activités d'amélioration de la qualité, ce qui inclut l'information la plus récente sur les erreurs et les événements indésirables.	!
5.3	Le personnel du laboratoire se réunit régulièrement avec les cliniciens. Référence ISO : 15189-07, 4.7	
5.4	Les membres du personnel approprié fournissent des conseils sur le choix des analyses et l'utilisation des services du laboratoire, y compris sur la fréquence des analyses et le type de spécimen requis. Référence ISO : 15189-07, 4.7	
5.6	Le laboratoire collabore avec des prestateurs cliniques et d'autres membres du personnel pour évaluer et améliorer les services.	
7.1	Le laboratoire cerne les besoins de chaque membre du personnel en matière d'orientation et de formation continue. Référence ISO : 15189-07, 4.12.5 et 5.1.9 Référence CSA : Z902-10, 4.3.2.1	
7.2	Tous les membres du personnel participent régulièrement à des activités de perfectionnement professionnel. Référence ISO : 15189-07, 5.1.9 Référence CSA : Z902-10, 4.3,2,2	
7.8	Le laboratoire évalue annuellement l'efficacité de ses activités de formation, de perfectionnement et d'évaluation des compétences, et il consigne les résultats de cette évaluation. Référence CSA : Z902-10, 4.3.2.3 et 4.3.3.1	
11.2	Le système de gestion des rapports du laboratoire est tel qu'il facilite la récupération des dossiers des clients avec précision et en temps opportun . Référence ISO : 15189-07, Annexe B6 Référence CSA : Z902-10, 20.1.1, 20.1.2, 20.1.8 et 20.1.9	

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13.3	Les aires de prélèvement du laboratoire assurent le confort et l'intimité des clients et sont adaptées aux personnes handicapées. Référence ISO : 15189-07, 5.2.3 Référence CSA : Z902-10, 22.4.2	!
17.5	Le laboratoire veille à ce que de l'équipement de secours soit disponible en cas d'urgence et qu'il soit en état de fonctionnement.	
21.2	La personne chargée de la sécurité a l'autorisation de mettre fin à toute activité en laboratoire jugée dangereuse.	!
24.3	Le laboratoire cerne des mesures appropriées pour contrôler l'utilisation des nouvelles interventions.	
24.4	Le laboratoire tient compte des directives relatives aux meilleures pratiques en matière d'adoption de nouveautés ou de progrès technologiques.	!
24.7	Le laboratoire vérifie régulièrement si les interventions continuent à correspondre à un niveau de qualité et de rendement attendu, et consigne les résultats.	!
25.6	Le laboratoire met en oeuvre et fait le suivi d'indicateurs de qualité en vue d'évaluer la contribution du laboratoire aux services aux patients et de communiquer ces résultats au personnel ainsi qu'aux autres programmes, services ou organismes. Référence ISO : 15189-07, 4.9	!

Commentaires des visiteurs pour ce(s) processus prioritaire(s)

Processus prioritaire : Services de diagnostic - Laboratoire

Les utilisateurs des services du laboratoire sont très satisfaits de la collaboration du personnel et de leur disponibilité. L'équipe du laboratoire est compétente et les ressources sont suffisantes. L'environnement physique est propre, largement suffisant pour les besoins et est sécuritaire. Les aires d'accès au laboratoire sont contrôlées. L'élimination des déchets bio médicaux suit un programme respectant les exigences.

Le manuel des procédures est révisé annuellement et est diffusé sur les unités de soins dans les deux langues et une version informatisée est disponible sur l'intranet. Une personne est assignée à la gestion de la qualité et à la santé-sécurité du laboratoire.

Les programmes d'entretien et de maintenance des appareils sont bien supervisés. La gestion des non-conformités fait aussi l'objet d'une attention particulière.

L'informatisation du laboratoire faciliterait l'accessibilité aux résultats, améliorerait la gestion des données, la distribution des résultats et préviendrait des erreurs qui pourraient avoir des conséquences sévères sur la sécurité des patients.

La mise en place d'un programme de formation faciliterait l'accès au perfectionnement et une mise à niveau des connaissances des technologistes.

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La définition d'indicateurs de qualité à partir des tendances, volumes de services, point de vue de la clientèle aiderait les gestionnaires du laboratoire à favoriser les meilleures pratiques.

Section 3 Résultats détaillés de la visite

3.2.3 Sections de normes : Normes d'imagerie diagnostique

Critère non respecté		Critères à priorité élevée
Processus prioritaire : Impact sur les résultats		
L'organisme s'est conformé à tous les critères pour ce processus prioritaire.		
Processus prioritaire : Services de diagnostic - Imagerie		
3.1	Un directeur médical supervise et dirige les prestateurs de services d'imagerie diagnostique.	!
3.2	Le directeur médical est un spécialiste de l'imagerie accrédité par l'association ou l'ordre professionnel approprié.	!
6.1	L'équipe possède un manuel détaillant ses politiques et ses procédures d'utilisation de l'équipement diagnostique, et celui-ci est signé par le directeur médical.	
6.9	Pour des raisons réglementaires, les versions antérieures du manuel des politiques et des procédures sont conservées pendant au moins dix ans.	
14.2	L'équipe nomme une personne responsable de la sécurité ou un comité de sécurité, ou les deux à la fois, pour assumer la responsabilité du programme de sécurité.	!
15.3	Tous les mois, l'équipe procède à une analyse des cas de rejet ou de répétition et produit un rapport à ce sujet dans le cadre de son programme de contrôle de la qualité.	!

Commentaires des visiteurs pour ce(s) processus prioritaire(s)

Processus prioritaire : Impact sur les résultats

Il y a peu d'activités à risque élevé dans le service d'imagerie diagnostique. La seule activité identifiée concerne les examens nécessitant une substance de contraste ingérée dans les cas suspects d'ulcère digestif qui commande le remplacement du baryum par la Gastrografin.

Processus prioritaire : Services de diagnostic - Imagerie

Les services de diagnostic en imagerie médicale comprennent des examens de graphie générale, de fluoroscopie, d'échographie, de panographie et un appareil mobile. Un technicien en imagerie assure les services de 9h à 13h30 sur place les jours de semaine ainsi qu'une garde en disponibilité de jour les fins de semaine et jours fériés.

Pendant la semaine, les services d'imagerie exécutent généralement 6 ou 7 examens par jour alors qu'en fin de semaine, il y a environ un appel par mois.

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Deux médecins spécialistes accrédités en imagerie se partagent les services d'imagerie de l'établissement à temps partiel. Ces radiologistes effectuent les examens de fluoroscopie et les échographies. Il n'y a pas de directeur médical spécialiste en imagerie accrédité.

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3.2.4 Sections de normes : Normes de gestion des médicaments

Critère non respecté		Critères à priorité élevée
Processus prioritaire : Gestion des médicaments		
2.5	L'organisme définit et établit la liste des médicaments de niveau de risque et d'alerte élevés dont il dispose.	!
2.6	L'organisme offre au personnel et aux prestateurs de services de la formation sur les nouveaux médicaments, avant qu'ils ne les utilisent.	!
3.9	L'organisme dispose d'une politique et d'un processus pour gérer les pénuries de médicaments.	
12.3	Le personnel de la pharmacie mélange les médicaments stériles et les solutions intraveineuses à la pharmacie en ayant recours à des techniques aseptiques ainsi qu'au matériel et à l'équipement de sécurité qui conviennent.	!
13.3	La pharmacie délivre des médicaments dans des contenants à dose unitaire.	!
21.3	L'organisme dispose d'un processus de contrôle de la qualité pour vérifier la conformité aux politiques liées aux médicaments comportant un risque accru d'événements indésirables.	
22.1	L'organisme sélectionne et contrôle les indicateurs de processus et de résultats pour l'utilisation et la gestion des médicaments.	
22.2	L'organisme contrôle l'utilisation des médicaments grâce à une revue continue de l'utilisation des médicaments.	
22.3	L'organisme dispose d'un programme de contrôle de la qualité pour la pharmacie.	

Commentaires des visiteurs pour ce(s) processus prioritaire(s)

Processus prioritaire : Gestion des médicaments

Le personnel de la pharmacie a instauré un système de distribution précis qui favorise l'administration sécuritaire des médicaments. De plus, des mécanismes de contrôle de qualité du système de distribution ont été implantés afin d'éviter les erreurs de distribution. Les pharmaciens du département sont très impliqués au sein de l'organisation, leur participation aux réunions interdisciplinaires, leur rôle dans les programmes de formation et leur implication dans l'implantation du bilan comparatif du médicament sont bien reconnus. De plus, plusieurs politiques et procédures ont été élaborées et implantées afin de bien encadrer le personnel soignant et les autres prestateurs.

Les pharmaciens du département ont plusieurs projets d'amélioration de la qualité. Par exemple, le suivi de certains indicateurs de qualité et les revues d'utilisation des médicaments font partie des projets du

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département. Ces projets viendraient promouvoir l'utilisation optimale de la médication au sein de l'organisation.

Le logiciel informatique du département de pharmacie ne semble pas répondre adéquatement aux besoins de la pharmacie. Les possibilités de développement du logiciel ne permettent pas de suivre l'évolution de la pharmacie et le logiciel comporte plusieurs imprécisions. Par exemple, il n'est pas possible de développer un outil pour le bilan comparatif du médicament ou d'améliorer les feuilles d'administration des médicaments.

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3.2.5 Sections de normes : Prévention des infections

Critère non respecté		Critères à priorité élevée
Processus prioritaire : Prévention des infections		
5.4	Le personnel, les prestateurs de services et les bénévoles participent au programme de formation sur la prévention des infections au moment de leur orientation et régulièrement par la suite.	
5.7	L'organisme surveille la conformité aux politiques et procédures relatives à la prévention des infections.	
7.3	L'information donnée aux clients et aux familles est consignée dans le dossier du client.	!

Commentaires des visiteurs pour ce(s) processus prioritaire(s)

Processus prioritaire : Prévention des infections

L'équipe de prévention des infections est proactive et présente au sein de l'organisation. L'élaboration et la mise à jour d'un programme de prévention des infections sont assurées par l'équipe. Plusieurs activités de promotion de la prévention des infections sont organisées annuellement et la participation des employés, des bénévoles, des clients et de leur famille est favorisée. Un plan de pandémie a été élaboré et le processus a impliqué tous les intervenants concernés. De plus, l'équipe de prévention des infections assure un suivi adéquat des taux d'infection conjointement avec le comité de prévention des infections. Les taux de conformité pour l'hygiène et le lavage des mains ont été compilés et analysés par l'équipe. Dans le but de maintenir et d'améliorer ces taux de conformité, plusieurs objectifs de promotion pour l'hygiène et le lavage des mains ont déjà été établis pour la prochaine année. L'équipe de prévention des infections est encouragée à vérifier la conformité à d'autres politiques et procédures reliées à la prévention des infections et à élaborer un plan de formation continu. Ceci permettrait de vérifier et de renforcer l'intégration du programme de prévention des infections au sein de l'organisation.
Le processus de retraitement et de stérilisation est conforme et répond aux besoins de l'organisation.

Le service d'alimentation a instauré un processus de contrôle de la qualité complet qui contribue à la prévention des infections. De plus, la formation adéquate du personnel est assurée.

Le service d'hygiène et de salubrité a instauré un système de contrôle du nettoyage et de la désinfection qui est très précis et qui donne de bons résultats. La propreté des lieux est observée par les intervenants ainsi que par les clients et leur famille. Le service d'hygiène et de salubrité travaille en étroite collaboration avec l'équipe de prévention des infections.

Il est à noter que pour la norme concernant le suivi des infections nosocomiales, le point traitant sur les infections des champs opératoires ne s'applique pas à l'organisme car il n'y a pas de service de chirurgie dans cet établissement.

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3.2.6 Sections de normes : Services de laboratoires biomédicaux

Critère non respecté		Critères à priorité élevée
Processus prioritaire : Services de diagnostic - Laboratoire		
2.2	Le manuel comprend les procédures concernant la préparation du client; l'identification du spécimen primaire devant être prélevé; le prélèvement du spécimen; et l'élimination en toute sécurité des matériaux utilisés pour prélever l'échantillon. Référence ISO : 15189, 5.4.3	
4.7	Si des analyses sont réalisées hors-laboratoire, la personne appropriée a recours aux mêmes processus et procédures.	!
4.8	Le personnel autorisé du laboratoire vérifie la pertinence des analyses effectuées. Référence ISO : 15189, 5.6.1	
6.1	L'organisme a précisé les situations pour lesquelles des tests et des analyses peuvent être effectués hors laboratoire.	!
6.2	Le laboratoire a désigné des membres du personnel pour effectuer et vérifier les analyses hors laboratoire.	!
6.3	Pendant la surveillance des analyses hors laboratoire, le laboratoire effectue un contrôle de la qualité pour chaque analyse.	!
7.4	Le rapport indique clairement si la qualité de l'échantillon primaire est inappropriée pour des fins d'analyse ou si elle peut avoir porté atteinte à l'intégrité des résultats finaux. Référence ISO : 15189, 5.8.5	
8.1	Le laboratoire extrait des indicateurs de qualité des résultats généraux des analyses.	!
8.2	Le laboratoire informe les prescripteurs de leur performance individuelle.	
8.3	Le laboratoire fait une vérification des résultats globaux et analyse les tendances générales.	
8.4	Le laboratoire utilise cette information dans le cadre de son système de gestion de la qualité pour apporter des améliorations aux services qui seront offerts à l'avenir.	!

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Commentaires des visiteurs pour ce(s) processus prioritaire(s)
Processus prioritaire : Services de diagnostic - Laboratoire

La distribution du cahier du laboratoire sur les unités de soins permet une bonne communication des exigences à rencontrer lors des demandes d'analyses. Le personnel du laboratoire travaille de façon sécuritaire lors de la manipulation des échantillons et la réalisation des analyses sur les spécimens. Un programme de contrôle de qualité externe est en place. Le système de qualité assure la transmission de résultats fiables et précis. La divulgation des non-conformités permet au personnel du laboratoire d'améliorer ses services. Les procédures sont rédigées selon un cadre formel qui respecte les exigences des normes et leur contenu est clair et facile d'accès.

Le laboratoire ne dispose pas de système informatique pour la transcription des résultats d'analyses. Ceci pourrait être la source d'erreur importante avec des conséquences significatives lors de la retranscription des résultats.
L'acheminement des résultats aux différents intervenants serait grandement amélioré si on informatisait les laboratoires.
De plus, la gestion des analyses hors laboratoire devrait être prise en charge de façon plus exhaustive afin de répondre aux exigences de la norme Z22870 sur les analyses de biologie délocalisées. Il semble que seuls les glucomètres soient utilisés hors laboratoire, il faudrait bien s'assurer que toutes les analyses hors laboratoire soient répertoriées et prises en charge par un comité. Le laboratoire est l'entité responsable de s'assurer la bonne gestion de ces appareils, le système de qualité, les formations des utilisateurs et l'inventaire des réactifs de ces appareils.

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3.2.7 Sections de normes : Services de soins de longue durée

Critère non respecté	Critères à priorité élevée
Processus prioritaire : Direction clinique	
L'organisme s'est conformé à tous les critères pour ce processus prioritaire.	
Processus prioritaire : Compétences	
L'organisme s'est conformé à tous les critères pour ce processus prioritaire.	
Processus prioritaire : Épisode de soins	
12.3 L'équipe établit le bilan comparatif des médicaments du client de concert avec le client, la famille ou le soignant aux points de transition lorsque les ordonnances de médicaments sont changées ou réécrites (c.-à-d., au moment d'un transfert à l'interne ou du congé). 12.3.1 Il existe un processus officiel éprouvé pour établir le bilan comparatif des médicaments avec le client aux points de transition lorsque les ordonnances de médicaments sont changées ou réécrites (c.-à-d. au moment du transfert à l'interne ou du congé). 12.3.2 L'équipe effectue, en temps opportun, une comparaison de la liste de médicaments complète et mise à jour et des nouvelles ordonnances de médicaments ou des changements récents. 12.3.3 L'équipe consigne le fait que le bilan de la liste de médicaments complète et mise à jour et des nouvelles ordonnances de médicaments ou des changements récents a été effectué, ainsi que le fait que les modifications appropriées ont été apportées aux médicaments lorsque cela s'avérait nécessaire. 12.3.4 Selon le point de transition, une liste de médicaments mise à jour est conservée dans le dossier du client (transfert à l'interne) OU une liste de médicaments mise à jour est transmise au prochain prestateur de soins (congé). 12.3.5 Ce processus s'avère une responsabilité partagée entre le client ou la famille, et un praticien en soins de santé ou plus, par exemple le personnel infirmier, les médecins et le personnel des pharmacies, selon le cas.	
12.8 Après le transfert d'un client, l'équipe communique avec celui-ci, sa famille ou l'organisme où il est soigné pour évaluer le succès de la transition. Les renseignements ainsi obtenus servent à améliorer la planification des transferts.	

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Processus prioritaire : Aide à la décision

L'organisme s'est conformé à tous les critères pour ce processus prioritaire.

Processus prioritaire : Impact sur les résultats

L'organisme s'est conformé à tous les critères pour ce processus prioritaire.

Commentaires des visiteurs pour ce(s) processus prioritaire(s)

Processus prioritaire : Direction clinique

L'hôpital Sainte-Anne connaît une décroissance au cours des dernières années. Il y a des projections sur la décroissance qui ont été établies. Des démarches de négociation sont en cours avec le gouvernement du Québec pour le transfert de l'hôpital Sainte-Anne au niveau provincial. Les profils de la clientèle sont faits au niveau du Ministère des Anciens Combattants.

Les membres du personnel rencontrés expriment qu'ils sont consultés sur les aspects qui les concernent.

Les étudiantes en soins infirmiers devraient être fortement encouragées à assister aux rencontres interdisciplinaires. Dans le cadre de leur apprentissage, il serait pertinent que les étudiants puissent assister et participer à ces réunions.

L'établissement adapte régulièrement et évalue les services offerts. Différents services ou approches ont été développés pour la clientèle comme par exemple: l'approche sensorielle Snoezelen, le programme de santé bucco-dentaire. Des projets de recherche sont en cours dans certains cas. L'établissement est invité à poursuivre ses démarches dans ce sens.

Processus prioritaire : Compétences

Des rencontres interdisciplinaires sont planifiées systématiquement selon les cadres et les membres du personnel rencontrés.

Les profils de postes existent mais demandent à être mis à jour. L'établissement a fait un travail important à ce niveau mais il reste à être complété.

Le personnel rencontré s'est dit satisfait des formations offertes par l'organisation et dit être fier de travailler à l'Hôpital Sainte-Anne.

Les évaluations du rendement du personnel sont faites annuellement et à la fin de la période de probation.

Processus prioritaire : Épisode de soins

Les critères d'admission à l'Hôpital Sainte-Anne sont élaborés par le Ministère des Anciens Combattants et appliqués par l'établissement.

L'établissement a élaboré une politique et procédures sur la double identification des résidents et applique cette pratique organisationnelle requise.

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L'établissement a produit une politique et procédures sur le bilan comparatif des médicaments à l'admission, aux transferts et aux congés ainsi qu'une procédure d'administration des médicaments datant de 2011. Le bilan comparatif des médicaments à l'admission et au transfert est appliqué dans tout l'établissement par le pharmacien et le médecin concerné. Toutefois, le bilan comparatif des médicaments devrait aussi être fait au congé. Les dirigeants sont invités à compléter le bilan comparatif des médicaments au congé.

L'équipe n'entre en contact avec le client après le transfert que dans des cas très particuliers. Un processus de suivi systématique au congé permettrait de mieux évaluer le succès de la transition.

L'établissement a un taux de contention de la clientèle très bas (3.2%) en 2011 et des suivis réguliers et rigoureux sont faits. De plus, des audits aux trois mois sont faits afin d'évaluer le processus de détermination de contention, d'exercer une surveillance, d'en évaluer le bien fondé et d'apporter des correctifs en collaboration avec les secteurs concernés.

L'établissement rend accessible aux clients ayant des problèmes de dysphagie une nourriture adaptée à leur condition ayant une apparence appétissante et les mêmes valeurs nutritives que les aliments conventionnels.

Processus prioritaire : Aide à la décision

L'équipe assure une transmission efficace et efficiente des renseignements entre les prestateurs de services.

Processus prioritaire : Impact sur les résultats

Des sondages de satisfaction sont faits systématiquement aux six semaines après l'arrivée du client, durant son hébergement et en fin de vie.

Des adaptations ont été installées dans les chambres et à différents endroits pour la prévention des chutes.

Des pictogrammes à la tête du lit du résident permettent d'assurer la sécurité et la continuité dans les services. L'établissement est invité à s'assurer que tous les pictogrammes respectent la confidentialité.

Section 3 Résultats détaillés de la visite

3.2.8 Sections de normes : Soins ambulatoires

Critère non respecté	Critères à priorité élevée
Processus prioritaire : Direction clinique	
L'organisme s'est conformé à tous les critères pour ce processus prioritaire.	
Processus prioritaire : Compétences	
L'organisme s'est conformé à tous les critères pour ce processus prioritaire.	
Processus prioritaire : Épisode de soins	
L'organisme s'est conformé à tous les critères pour ce processus prioritaire.	
Processus prioritaire : Aide à la décision	
L'organisme s'est conformé à tous les critères pour ce processus prioritaire.	
Processus prioritaire : Impact sur les résultats	
17.4 L'équipe informe et forme les clients et les familles au sujet de leur rôle en ce qui concerne la sécurité par le biais de communications écrites et verbales. 17.4.1 Les clients et les familles reçoivent de l'information écrite et verbale au sujet de leur rôle en matière de sécurité. 17.4.2 Le personnel utilise des méthodes écrites et verbales pour informer et former les clients au sujet du rôle qu'ils jouent dans le dossier de la sécurité.	

Section 3 Résultats détaillés de la visite

Commentaires des visiteurs pour ce(s) processus prioritaire(s)

Processus prioritaire : Direction clinique

L'équipe au Centre de Liaison est formée d'un personnel dynamique qui offre des services de grande qualité à sa clientèle. L'équipe travaille en interdisciplinarité et le client participe activement à sa prise en charge. Un plan de qualité de vie adapté est élaboré pour chaque client. Les activités offertes par le Centre de Liaison répondent adéquatement aux besoins de cette clientèle. Le taux de satisfaction des clients est très élevé. De plus, un suivi rigoureux du nombre de participation aux activités est assuré par l'équipe au Centre de Liaison. À cause de la diminution du nombre d'Anciens Combattants, le nombre de participation aux activités a décliné depuis les dernières années. Les activités offertes au Centre de Liaison devront être adaptées à cette réalité et au déclin qui se poursuit. L'équipe au Centre de Liaison a élaboré un plan stratégique qui tient compte de cette réalité.

Il serait intéressant et favorable de mesurer les effets cliniques des différents services offerts au Centre de Liaison afin de valider s'ils ont un impact sur la morbidité des usagers (par exemple, le maintien de la capacité physique).

Processus prioritaire : Compétences

Aucun commentaire n'a été émis.

Processus prioritaire : Épisode de soins

Aucun commentaire n'a été émis.

Processus prioritaire : Aide à la décision

Aucun commentaire n'a été émis.

Processus prioritaire : Impact sur les résultats

Aucun commentaire n'a été émis.

Section 4 Résultats qui découlent des mesures de rendement

Dans le cadre du programme Qmentum, les organismes clients procèdent à la collecte de données découlant des mesures du rendement en se servant d'indicateurs et de sondages.

- Les **sondages** sont des questionnaires qui portent sur des secteurs comme la gouvernance, la culture de sécurité des patients et la qualité de vie au travail. Ils sont remplis par un échantillon de représentants des clients, du personnel, de la haute direction, des membres du conseil d'administration et d'autres partenaires.

L'information contenue dans cette section fait état de quelques résultats des mesures de rendement à l'échelle de l'organisme.

4.1 Outils

4.1.1 Sondage sur la culture de sécurité des patients

Le Sondage sur la culture de sécurité des patients fournit de précieux renseignements sur les perceptions du personnel à l'égard de la sécurité des patients, ainsi qu'une indication des points forts et des possibilités d'amélioration dans plusieurs secteurs qui se rapportent à la sécurité des patients et à la qualité de vie au travail.

Agrément Canada a fourni à l'organisme des résultats détaillés provenant du Sondage sur la culture de sécurité des patients avant la visite, par le biais du plan d'amélioration de la qualité du rendement qui se trouve dans le portail des organismes clients. L'organisme a ensuite eu la possibilité de s'occuper des secteurs qui posent un défi. Pendant la visite, les visiteurs ont examiné les progrès réalisés dans ces secteurs.

Période de collecte de données : 16 septembre 2010 au 2 décembre 2010

Taux de réponse minimum (fondé sur le nombre d'employés) : 259

Nombre de répondants : 423

Taux minimum de répondants ATTEINT

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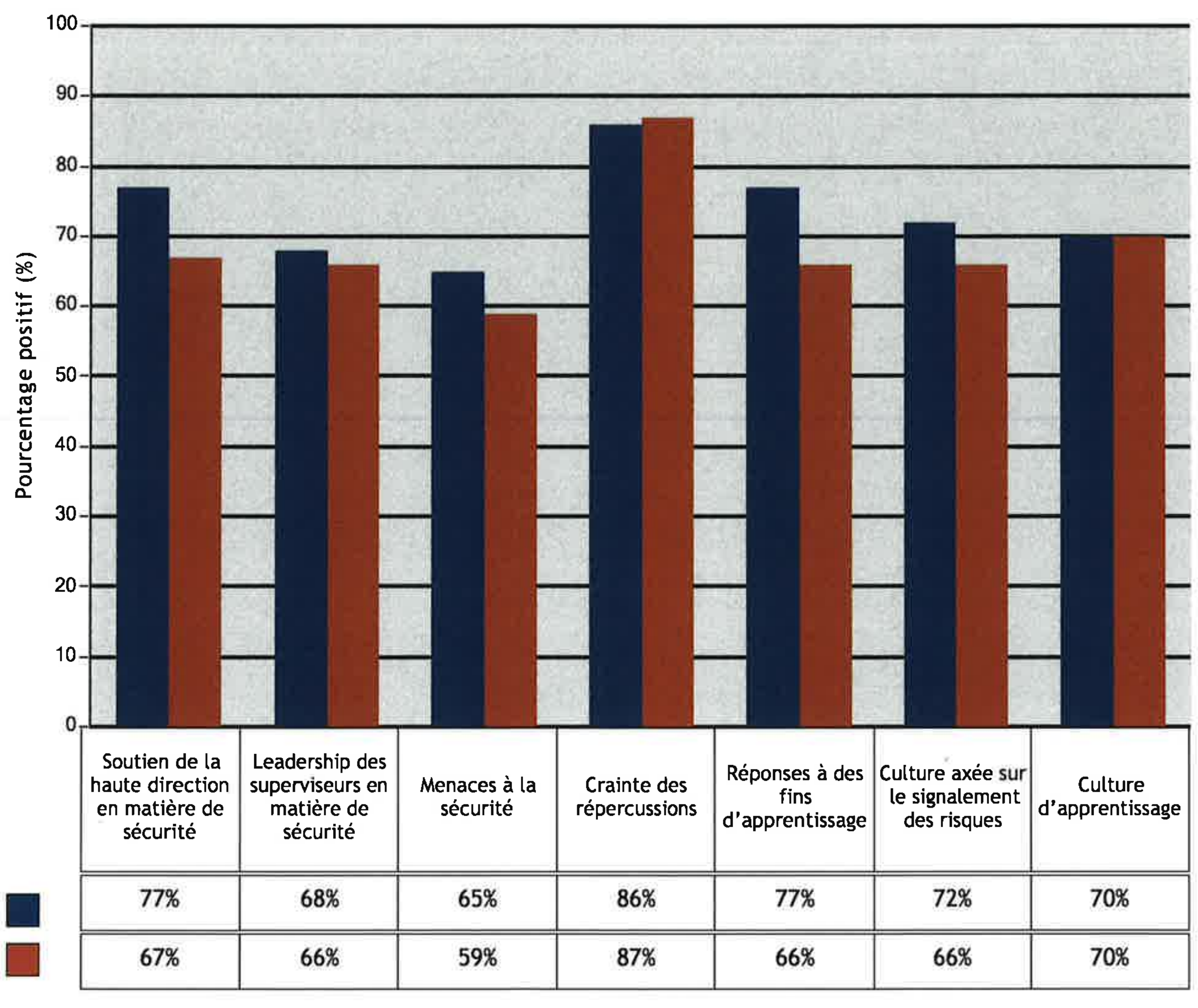
Section 4 Résultats qui découlent des mesures de rendement

Culture de Sécurité des patients: résultats par dimension de la culture de sécurité des patients

Résultats relatifs aux sondage sur la culture de sécurité des patients



	Soutien de la haute direction en matière de sécurité	Leadership des superviseurs en matière de sécurité	Menaces à la sécurité	Crainte des répercussions	Réponses à des fins d'apprentissage	Culture axée sur le signalement des risques	Culture d'apprentissage
Hôpital Sainte-Anne	77%	68%	65%	86%	77%	72%	70%
* Moyenne canadienne	67%	66%	59%	87%	66%	66%	70%

Légende

- Hôpital Sainte-Anne
- * Moyenne canadienne

*Moyenne canadienne : Pourcentage d'organismes clients d'Agrément Canada visités de juillet à décembre 2010 qui sont d'accord avec les éléments de l'outil.

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Section 4 Résultats qui découlent des mesures de rendement

4.1.2 Sondage Pulse sur la qualité de vie au travail

Le Sondage Pulse sur la qualité de vie au travail permet aux organismes de prendre le pouls de la qualité de vie au travail en évaluant la perception du personnel à l'égard de plusieurs éléments de la vie au travail, comme la communication au travail, la santé et le bien-être du personnel, et la satisfaction à l'égard du travail. Il permet de recueillir de l'information sur onze éléments relatifs au milieu de travail qui sont reconnus pour contribuer à la qualité de vie au travail au plan individuel ainsi qu'au rendement de l'organisme.

Agrément Canada a fourni à l'organisme des résultats détaillés provenant du Sondage Pulse sur la qualité de vie au travail avant la visite, par le biais du plan d'amélioration de la qualité du rendement qui se trouve dans le portail des organismes clients. L'organisme a ensuite eu la possibilité de s'occuper des secteurs qui posent un défi. Pendant la visite, les visiteurs ont examiné les progrès réalisés dans ces secteurs.

Période de collecte de données : 16 septembre 2010 au 2 décembre 2010

Taux de réponse minimum (fondé sur le nombre d'employés) : 259

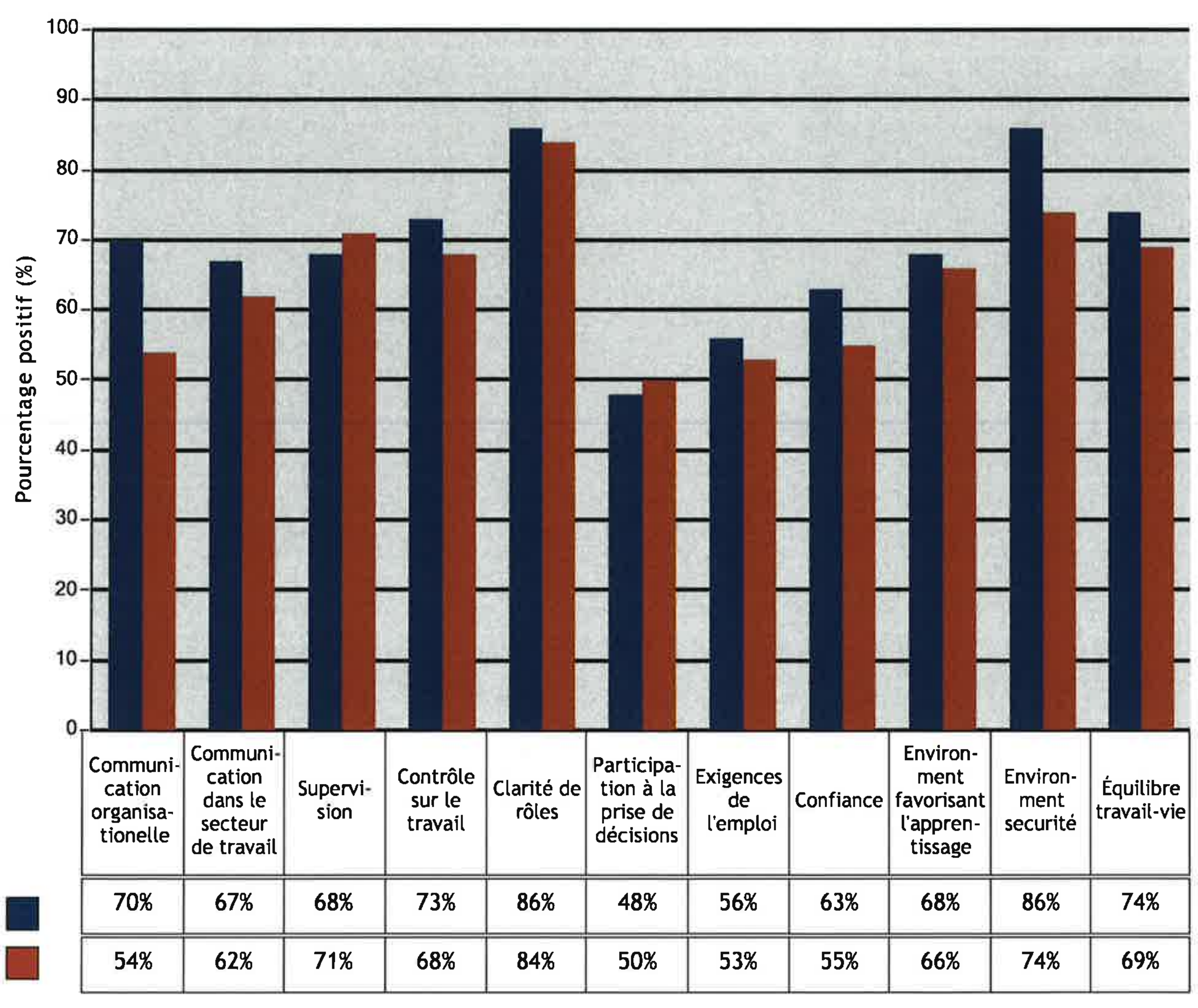
Nombre de répondants : 518

Taux minimum de répondants ATTEINT

Section 4 Résultats qui découlent des mesures de rendement

Sondage Pulse sur la qualité de vie au travail : résultats selon les éléments du milieu de travail

Résultats du Sondage Pulse sur la qualité de vie au travail



	Communication organisationelle	Communication dans le secteur de travail	Supervision	Contrôle sur le travail	Clarité de rôles	Participation à la prise de décisions	Exigences de l'emploi	Confiance	Environnement favorisant l'apprentissage	Environnement securité	Équilibre travail-vie
Hôpital Sainte-Anne	70%	67%	68%	73%	86%	48%	56%	63%	68%	86%	74%
* Moyenne canadienne	54%	62%	71%	68%	84%	50%	53%	55%	66%	74%	69%

Légende

- Hôpital Sainte-Anne
- * Moyenne canadienne

*Moyenne canadienne : Pourcentage d'organismes clients d'Agrément Canada visités de juillet à décembre 2010 qui sont d'accord avec les éléments de l'outil.

Section 5 Commentaires de l'organisme

Après la visite, l'organisme a été invité à fournir des commentaires devant être intégrés au rapport à propos de son expérience du programme et du processus d'agrément. Ces commentaires figurent ci-dessous.

Notre établissement a particulièrement apprécié la compétence et le professionnalisme des visiteurs d'Agrément Canada. Soigneusement choisi, chacun d'eux avait un parcours humain et professionnel impressionnant qui en faisait des personnes extrêmement bien placées pour évaluer, de façon autant critique que constructive, les enjeux, les façons de faire, la culture et les spécificités de notre Hôpital.

Soulignons par ailleurs qu'ils ont su créer un climat détendu propice aux échanges grâce à leur maîtrise approfondie des divers domaines évalués comme des normes en vigueur, à leur écoute généreuse et à leur intérêt manifeste envers les présentations et les équipes qu'ils ont rencontrées. Nous avons grandement apprécié leur sensibilité à nos particularités d'établissement fédéral.

La qualité des visiteurs et celle de leur approche nous a permis de bien démontrer nos forces. Nous sommes donc très fiers de la note globale de 93,4% que nous avons obtenue, car nous sommes convaincus qu'elle reflète la grande qualité des soins et services que nous offrons à notre clientèle. C'est en effet, en soi, une reconnaissance très motivante pour nos équipes déjà bien animées par leur quête d'excellence au service du bien-être de nos résidents.

Annexe A Qmentum

L'agrément des services de santé contribue à l'amélioration de la qualité et à la sécurité des patients en permettant à un organisme de santé d'évaluer et d'améliorer ses services de façon régulière et constante. Le programme Qmentum d'Agrément Canada offre un processus adapté aux besoins et aux priorités de chaque organisme client.

Dans le cadre du processus d'agrément Qmentum, les organismes clients remplissent les questionnaires d'auto-évaluation, transmettent des données découlant des mesures de rendement, et participent à une visite d'agrément durant laquelle des visiteurs pairs dûment formés évaluent leurs services par rapport à des normes nationales d'excellence. L'équipe de visiteurs fournit les résultats préliminaires à l'organisme à la fin de la visite. Agrément Canada examine ces résultats et produit un rapport d'agrément dans les 10 jours ouvrables qui suivent la visite.

Le plan d'amélioration de la qualité du rendement que l'on trouve en ligne s'avère un complément important au rapport d'agrément; celui-ci est offert aux organismes clients dans leur portail. L'information contenue dans ce plan est utilisée conjointement avec le rapport d'agrément pour assurer l'élaboration de plans d'action détaillés.

Tout au long du cycle de trois ans, Agrément Canada assurera un lien et un soutien constants dans le but d'aider l'organisme à s'occuper des problématiques relevées, à établir un plan d'action et à faire le suivi de ses progrès.

Établissement d'un plan d'action

Après la visite, l'organisme se sert de l'information contenue dans son rapport d'agrément et son plan d'amélioration de la qualité du rendement pour élaborer des plans d'action visant à donner suite aux possibilités d'amélioration relevées. L'organisme transmet à Agrément Canada les preuves des mesures prises pour satisfaire à ces conditions.

Évaluation des progrès et amélioration continue

Cinq mois après la visite, Agrément Canada évalue les preuves transmises par l'organisme. Si ces preuves démontrent qu'il y a maintenant conformité à un pourcentage suffisant de critères qui n'étaient pas respectés auparavant, un nouveau type d'agrément pourrait être attribué pour tenir compte des progrès de l'organisme.

Annexe B Processus prioritaires

Processus prioritaires qui se rapportent aux normes qui touchent l'ensemble du système

Processus prioritaire	Description
Planification et conception des services	Élaborer et mettre en œuvre l'infrastructure, les programmes et les services nécessaires pour répondre aux besoins des populations et des communautés desservies.
Gestion des ressources	Surveiller, administrer et intégrer les activités touchant l'allocation et l'utilisation des ressources.
Capital humain	Renforcement de la capacité des ressources humaines à fournir des services sécuritaires et de grande qualité.
Gestion intégrée de la qualité	Avoir recours à un processus proactif, systématique et continu pour gérer et intégrer la qualité, et pour atteindre les buts et les objectifs de l'organisme.
Prestation de soins et prise de décisions fondées sur des principes	Cerner les dilemmes et les problèmes relatifs à l'éthique et prendre les décisions qui s'imposent.
Communication	Assurer une communication efficace à tous les paliers de l'organisme et avec les partenaires de l'externe.
Environnement physique	Fournir des structures et des établissements appropriés et sécuritaires pour réaliser la mission, la vision et les buts de l'organisme.
Préparation en vue de situations d'urgence	Gérer les urgences, les sinistres ou autres aspects relevant de la sécurité publique, et planifier en ce sens.
Cheminement des clients	Évaluation du déplacement sans heurt et en temps opportun des clients et des familles entre les services et les milieux de soins.
Équipement et appareils médicaux	Obtenir et entretenir du matériel et des technologies qui servent au diagnostic et au traitement de problèmes de santé.

Processus prioritaires qui se rapportent à des normes relatives à des populations spécifiques

Processus prioritaire	Description
Gestion des maladies chroniques	Intégration et coordination des services de l'ensemble du continuum de soins pour répondre aux besoins des populations vivant avec une maladie chronique.

Annexe B Processus prioritaires

Processus prioritaire	Description
Santé et bien-être de la population	Promouvoir et protéger la santé des populations et des communautés desservies grâce au leadership, au partenariat et à l'innovation.

Processus prioritaires qui se rapportent aux normes sur l'excellence des services

Processus prioritaire	Description
Analyses de biologie délocalisées	Recourir à des analyses hors laboratoire, à l'endroit où les soins sont offerts, pour déterminer la présence de problèmes de santé.
Transplantation d'organes	Offrir des services de transplantation d'organes, à partir de l'évaluation initiale des receveurs potentiels jusqu'à la prestation des services de suivi aux greffés.
Épisode de soins primaires	Offrir des soins primaires en milieu clinique, y compris rendre les services de soins primaires accessibles, terminer l'épisode de soins et coordonner les services.
Don d'organes (donneur vivant)	Offrir des services de don d'organes provenant de donneurs vivants, par exemple, en appuyant les donneurs potentiels dans une prise de décisions éclairée, en effectuant des analyses d'acceptabilité du donneur et en réalisant des procédures liées aux dons d'organes.
Direction clinique	Diriger et guider les équipes qui offrent les services.
Compétences	Créer une équipe interdisciplinaire dotée des connaissances et du savoir-faire nécessaires pour gérer et offrir des programmes et des services efficaces.
Épisode de soins	Offrir des services de santé coordonnés aux clients à partir du premier contact avec un prestateur de soins jusqu'à la dernière rencontre liée à leur problème de santé.
Aide à la décision	Se servir de l'information, de la recherche, des données et de la technologie pour appuyer la gestion et la prise de décisions d'ordre clinique.
Impact sur les résultats	Cerner et assurer le suivi des mesures de processus et de résultats pour évaluer et améliorer la qualité des services et les résultats des clients.
Gestion des médicaments	Avoir recours à des équipes interdisciplinaires pour gérer la prestation des services de pharmacie.
Don d'organes (donneur décédé)	Offrir des services de don d'organes aux donneurs décédés et à leurs familles, ce qui englobe l'identification des donneurs potentiels, la communication avec les familles et le prélèvement des organes.

Annexe B Processus prioritaires

Processus prioritaire	Description
Prévention des infections	Instaurer des mesures pour prévenir et réduire l'acquisition et la transmission d'infections chez le personnel, les prestateurs de services, les clients et les familles.
Interventions chirurgicales	Offrir des soins chirurgicaux sécuritaires, ce qui englobe la préparation préopératoire, les interventions en salle d'opération, le rétablissement postopératoire et le congé.
Services de diagnostic - Imagerie	Assurer la disponibilité de services d'imagerie diagnostique pour aider les professionnels de la santé à établir un diagnostic pour leurs clients et à surveiller leurs problèmes de santé.
Services de diagnostic - Laboratoire	Assurer la disponibilité de services de laboratoire pour aider les professionnels de la santé à établir un diagnostic pour leurs clients et à surveiller leurs problèmes de santé.
Banques de sang et services transfusionnels	Manipulation sécuritaire du sang et des produits sanguins labiles, ce qui englobe la sélection du donneur, le prélèvement sanguin et la transfusion.

No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

WOLF WILLIAM SOLKIN

Plaintiff

vs.

THE ATTORNEY GENERAL OF CANADA

-and-

THE ATTORNEY GENERAL OF QUEBEC

-and-

THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

LIST OF EXHIBITS AGC-1 TO AGC-25
IN SUPPORT OF THE DEFENCE
OF THE ATTORNEY GENERAL OF CANADA

EXHIBIT AGC-6

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O/Ref : 9683661 BC0565

Canada Québec

Media Advisory

April 26, 2012

Ministers Blaney and Bolduc at Ste. Anne's Hospital

Ottawa – The Honourable Steven Blaney, Minister of Veterans Affairs, Doctor Yves Bolduc, Minister of Health and Social Services for the Government of Quebec, Senator Larry Smith and Mr. Geoffrey Kelley, Minister responsible for Aboriginal Affairs and Member of the National Assembly for Jacques-Cartier, will be at Ste. Anne's Hospital to provide an update on the future of the Hospital.

Accredited media representatives are invited to attend.

Location: Ste. Anne's Hospital*
305 Veterans Boulevard
Sainte-Anne-de-Bellevue, Quebec

Date: April 27, 2012

Time: 2:30 p.m.

The media are invited to speak with Minister Blaney and Minister Bolduc.

*The media are asked to use the Remembrance Pavilion entrance.

– 30 –

Media inquiries:
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Canada

Notes d'allocution de
L'HONORABLE

Speaking notes for
THE HONOURABLE

Steven Blaney

Ministre des Anciens Combattants

Minister of Veterans Affairs

Allocution adressée aux médias

Annonce sur le projet de transfert de l'Hôpital Sainte-Anne

Hôpital Sainte-Anne
Vendredi, le 27 avril 2012

Le discours prononcé fait foi

Please check against delivery

Merci.

Ministre Bolduc,

Sénateur [Larry] Smith,

Monsieur le maire [Francis Deroo],

Chers vétérans,

Représentants des médias,

Bonjour et merci d'être venus.

Je suis heureux d'être des vôtres aujourd'hui, à l'Hôpital Sainte-Anne, une institution qui jouit d'une longue et fière tradition.

Comme vous le savez, notre gouvernement est fermement engagé à servir les anciens combattants et les vétérans et à leur fournir les soins dont ils ont besoin. Nous sommes reconnaissants des sacrifices qu'ils ont faits pour notre pays. Notre mandat premier est de leur témoigner toute la gratitude qu'ils méritent, pour les courageux efforts qu'ils ont déployés.

We all know that Ste. Anne's Hospital is one of the best long-term care facilities in the country. And we can all agree that its future is promising.

L'Hôpital Sainte-Anne a été construit en 1917 par la Commission des hôpitaux militaires pour soigner les hommes et les femmes qui avaient combattu durant la Première Guerre mondiale. Après la Seconde Guerre mondiale, le ministère des Anciens Combattants a fait l'acquisition de l'Hôpital Sainte-Anne et d'autres établissements du genre au pays en raison des besoins complexes des anciens combattants et du manque d'établissements médicaux au pays pouvant répondre à ces besoins.

Depuis les années 60, le gouvernement du Canada a comme politique de transférer tous ces hôpitaux aux provinces. Il en était ainsi car, après l'adoption de la *Loi canadienne sur la santé* et l'instauration du régime d'assurance-maladie, la responsabilité en matière de santé a été transférée aux provinces.

L'annonce d'aujourd'hui n'est qu'une démonstration supplémentaire de la volonté de notre gouvernement de pratiquer un fédéralisme d'ouverture et de respecter ainsi les compétences québécoises.

To date, 17 establishments that were once administered by Veterans Affairs Canada have been transferred to the provinces. Previous transfers were met with great success, with the federal government continuing to financially support the level of care to Veterans. That's because they were done with the utmost consideration for Veterans and their families and care was taken to protect their interests.

[APG]

Comme vous le savez, l'Hôpital Sainte-Anne est le dernier hôpital administré par Anciens Combattants Canada.

Depuis quelques mois, le gouvernement du Canada et le gouvernement du Québec négocient un éventuel transfert de l'établissement.

Aujourd'hui, je suis heureux d'annoncer que le ministre québécois de la Santé et des Services sociaux, monsieur Yves Bolduc, et moi-même signerons un accord de principe concernant le transfert de l'Hôpital au gouvernement du Québec. Nous sommes fiers d'avoir franchi cette étape importante, qui constitue le premier engagement officiel des deux gouvernements d'aller de l'avant avec le transfert.

[APG]

Cependant, avant d'aller plus loin, je tiens à préciser que la priorité de ce gouvernement est de s'assurer que les anciens combattants conservent leur priorité d'accès à l'Hôpital Sainte-Anne, et continuent d'y recevoir les soins et les services exceptionnels qui y sont offerts à l'heure actuelle. En aucune circonstance allons-nous compromettre les soins offerts aux anciens combattants du Canada.

In terms of discussions, I want to assure you that both levels of government are working hard to ensure the interests of everyone involved are considered and treated with respect.

L'accord de principe comporte les principaux éléments sur lesquels les parties doivent s'entendre avant de conclure les négociations pour effectuer un transfert d'ici le 31 mars 2013.

Ces éléments sont :

- le maintien de l'accès prioritaire des anciens combattants admissibles à tous les services, les programmes et les soins de santé offerts à l'Hôpital;
- les niveaux garantis de soins et de services;
- les obligations en matière de langues officielles; et
- le coût du transfert.

Bilingualism is very important. I want to specify that one of our Government's priorities is to ensure Veterans continue to receive care in the official language of their choice.

Je voudrais prendre un moment pour parler de la réalité démographique de la situation actuelle.

Malheureusement, le nombre d'anciens combattants traditionnels au Québec qui ont besoin de soins de longue durée diminue à un rythme constant. Nous ne pouvons plus continuer à exploiter un hôpital qui se spécialise en soins gériatriques, pour les anciens combattants âgés, s'il n'y en a plus suffisamment.

Et que penser de laisser des lits vacants, alors que bien des personnes âgées de Montréal et des environs pourraient elles aussi profiter des soins exceptionnels qu'offre l'Hôpital Sainte-Anne.

Quand on se demande comment protéger les employés de grand calibre qui travaillent ici, tout en maintenant le niveau d'expertise alors que le nombre d'anciens combattants admissibles diminue, la seule réponse qui vient à l'esprit est de transférer l'administration de l'Hôpital Sainte-Anne au gouvernement du Québec.

[APG]

Grâce au transfert, les employés pourront continuer à offrir leur expertise en gériatrie et en psycho-gériatrie, à vivre là où sont leurs racines, à contribuer à l'économie locale et à exercer la profession qu'ils aiment et dans le cadre de laquelle ils excellent.

The outstanding care this hospital is known for will continue to be delivered by an outstanding group of health care professionals.

That will not change.

J’ai pleinement confiance que l’Hôpital est prêt à relever les défis qui se posent à lui et a beaucoup à offrir aux anciens combattants, à la population environnante, au Québec et au pays, et ce, pour encore bien longtemps.

Merci.

– 30 –

[APG]

Canada

News Release

FOR IMMEDIATE RELEASE April 27, 2012

Harper and Charest Governments Sign Agreement in Principle for the Potential Transfer of Ste. Anne's Hospital

Sainte-Anne-de-Bellevue, Quebec – The Honourable Steven Blaney, Minister of Veterans Affairs, and Doctor Yves Bolduc, Minister of Health and Social Services for the Government of Quebec, today signed an agreement in principle to establish a negotiation framework between the Government of Canada and the Government of Quebec for the eventual transfer of Ste. Anne's Hospital.

"Our Government is pleased to announce the signing of this agreement in principle with the Government of Quebec. This is an important step toward undertaking the necessary discussions between our two governments so that the Veterans living at Ste. Anne's Hospital can continue to receive, in English or in French, the exceptional care and service they deserve," said Minister Blaney. "One of my priorities is also to ensure the retention of our professionals and the transfer of the Hospital to the Government of Quebec should allow us to maintain their expertise. Today's announcement is further proof of our Government's commitment to practice open federalism and it demonstrates our respect for Quebec's jurisdiction."

"Like other seniors in our society, Veterans want access to high quality health care services, within their community. If we integrate Ste. Anne's Hospital into our network, our real concern will be to maintain the quality of care offered there, and the expertise in geriatrics and psychogeriatrics that characterizes it, while respecting the Hospital's organizational culture and the rich legacy of our Veterans. Moreover, with the falling demand in long-term care for Veterans, this transfer should allow us to meet the civilian population's need for beds in the Montréal area," said Minister Bolduc.

This agreement in principle is the first official commitment between both levels of government to move forward with the transfer of the Hospital. It identifies the key elements that both parties must agree to before concluding negotiations. These elements include maintaining priority access for eligible Veterans to all services, programs and health care offered at Ste. Anne's; guarantees for levels of care and services provided; delivery of care and services to Veterans in their choice of English or French; elements related to human resources; and evaluation of assets.

"I am very pleased to see the signing of this agreement in principle, because it really is a first step between the Government of Quebec and the Government of Canada to establish the

parameters that will allow Veterans to continue to have access to the quality care offered by this institution, the hospital staff to continue to make the most of its expertise, and the local population to gradually benefit from these hospital beds," added Geoffrey Kelley, Minister of Aboriginal Affairs and Member of the National Assembly for Jacques-Cartier.

"I am confident that this transfer will maintain the high quality of care that we, Veterans, receive at Ste. Anne's Hospital, and that both governments will do what it takes to uphold their commitments in this regard," added Mr. Marcel Otis, President of the Ste. Anne's Hospital Residents Committee.

The transfer of Ste. Anne's Hospital will provide long-term benefits to Veterans, Hospital staff and Quebec residents alike. There is a declining demand for long-term care beds for traditional Veterans at the Hospital. Transferring Ste. Anne's Hospital to the Government of Quebec will therefore maintain and maximize the Hospital's expertise in geriatrics and psychogeriatrics, and will provide bed availability for other Canadians.

– 30 –

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No. 500-06-000952-180

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-and-

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-and-

THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

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IN SUPPORT OF THE DEFENCE
OF THE ATTORNEY GENERAL OF CANADA

EXHIBIT AGC-7

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PC Number: 2014-0902

Date: 2014-08-01

His Excellency the Governor General in Council, on the recommendation of the Minister of Veterans Affairs, pursuant to section 4 of the *Department of Veterans Afairs Act*, authorizes the Minister of Veterans Affairs, with respect to the transfer of Ste. Anne's Hospital, to enter into, on behalf of the Government of Canada, an agreement with the Government of Quebec and the Hôpital Sainte-Anne, substantially in accordance with the annexed draft agreement.

Sur recommandation du ministre des Anciens Combattants et en vertu de l'article 4 de la *Loi sur le minisère des Anciens Combattants*, Son Excellence le Gouverneur général en conseil autorise celui-ci, relativement à la cession de l'hôpital Sainte-Anne à conclure, au nom du gouvernement du Canada, une entente conforme en substance au projet d'entente ci-joint, avec le gouvernement du Québec et l'Hôpital Sainte-Anne.

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No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

WOLF WILLIAM SOLKIN

Plaintiff

vs.

THE ATTORNEY GENERAL OF CANADA

-and-

THE ATTORNEY GENERAL OF QUEBEC

-and-

THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

LIST OF EXHIBITS AGC-1 TO AGC-25
IN SUPPORT OF THE DEFENCE
OF THE ATTORNEY GENERAL OF CANADA

EXHIBIT AGC-8

Attorney General of Canada

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O/Ref : 9683661 BC0565

AGC-9

CANADA

PRIVY COUNCIL • CONSEIL PRIVÉ

C.P. 2015-432
1er avril 2015

Sur recommandation du ministre des Anciens Combattants et en vertu de l'article 4 de la *Loi sur le ministère des Anciens Combattants*, Son Excellence le Gouverneur général en conseil :

a) abroge le décret C.P. 2014-902 du 1er août 2014;

b) autorise le ministre des Anciens Combattants, relativement à la cession de l'hôpital Sainte-Anne, à conclure, au nom du gouvernement du Canada, une entente conforme en substance au projet d'entente ci-joint avec le gouvernement du Québec et le Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal.

CERTIFIED TO BE A TRUE COPY COPIE CERTIFIÉE CONFORME

CLERK OF THE PRIVY COUNCIL LA GREFFIÈRE DU CONSEIL PRIVÉ

CANADA
PRIVY COUNCIL • CONSEIL PRIVÉ

P.C. 2015-432
April 1, 2015

His Excellency the Governor General in Council, on the recommendation of the Minister of Veterans Affairs, pursuant to section 4 of the *Department of Veterans Affairs Act*,

(*a*) repeals Order in Council P.C. 2014-902 of August 1, 2014; and

(*b*) authorizes the Minister of Veterans Affairs, with respect to the transfer of Ste. Anne's Hospital, to enter into, on behalf of the Government of Canada, an agreement with the Government of Quebec and the Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal, substantially in accordance with the annexed draft agreement.

CERTIFIED TO BE A TRUE COPY COPIE CERTIFIÉE CONFORME

CLERK OF THE PRIVY COUNCIL–LA GREFFIÈRE DU CONSEIL PRIVÉ

No. 500-06-000952-180

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EXHIBIT AGC-9

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May 6, 2015

Summary of Information Given to Residents/Clients and Their Family Members on April 29, 2015

Ste. Anne's Hospital Transfer Project

Transfer project background

Ste. Anne's Hospital (SAH) is the last hospital under federal government jurisdiction. Since the introduction of health insurance in the late 60s, the federal government's policy has been to transfer its hospitals to the provinces, which are responsible for health care.

Since then, Veterans Affairs Canada has successfully transferred 17 of its facilities. During each transfer, the Department made sure that the quality of care for veterans remained the priority. Close ties have been maintained with all the facilities transferred in the past, and veterans' level of satisfaction with the care they receive is very high.

There has been a decrease in the number of beds required for long-term care for traditional veterans over the last several years. As a result, three 33-bed units at SAH are currently closed, and an additional 20 or so beds are vacant. In all, approximately 120 or 446 beds are unoccupied, and eligible veterans are admitted without delay.

SAH is a leading-edge facility whose unique expertise is invaluable. For both the Department and the general public, it was of the utmost importance for this expertise to be passed on. It was therefore necessary to actively prepare for the future.

The transfer will make it possible to maintain and maximize SAH's expertise in long-term care, while increasing the number of beds available to other Quebecers who need them.

Transfer project timetable

The Government of Canada and the Government of Quebec reached a milestone in April 2015 when they signed the agreement paving the way for the transfer of SAH to provincial jurisdiction.

According to the agreement, SAH is expected to be transferred on April 1, 2016. If that date needs to be postponed for administrative reasons, the Government of Quebec will inform us by November 1, 2015.

[APG]

Care and services

The Government of Canada's main priority during negotiations with the Government of Quebec was to ensure that each eligible veteran would continue to receive outstanding care and services in their preferred language after the transfer.

To that end, the Government of Canada will help finance the enhancement of care and services provided at SAH after the transfer.

The financial contribution will apply to several components, such as:

- Nursing care and on-duty physicians;
- Professional services;
- Various other services (e.g. pastoral care and recreation).

Therefore, not only will the level of care provided veterans be maintained, but also the activities they enjoy will continue.

In addition, care and services will be offered in French and English, as each veteran chooses.

Veterans Affairs Canada will also monitor the quality of care provided at the hospital, as it does for all the other hospitals transferred previously.

Admission of civilians and priority access for veterans

Within a reasonable length of time following the transfer, civilians will be admitted to SAH in accordance with terms and conditions established by the Government of Quebec. This will make beds that are currently vacant available to meet the needs of members of the public. Who knows, these could be veterans' spouses, brothers and sisters, or friends and neighbours.

That being said, it is clear in the transfer agreement that eligible veterans will be given priority access to the hospital.

Transition committee to be formed

A transition committee will be set up and operate for about three years after the transfer date to monitor the situation and ensure that the conditions and obligations set out in the agreement are met, and to support the smooth transfer of SAH to the Quebec health and social services network.

Lieutenant-General (retired) Michel Maisonneuve will sit on the transition committee as veterans' representative. He has extensive military experience and, as a current

member of the Board of Directors of the SAH Foundation, he is thoroughly familiar with how the hospital operates.

The transition committee will also include members from Veterans Affairs Canada and the Quebec Department of Health and Social Services.

Other important facts

The Liaison Day Centre program will continue to be offered to eligible veterans for as long as there is a need.

The two operational stress injury clinics located at SAH, namely the Operational Stress Injury Clinic and the Residential Treatment Centre for Operational Stress Injuries, will be run by the province, as is the case with operational stress injury clinics elsewhere in the country. Funding for the clinics will continue to be provided by the federal government.

The negotiated visitor parking fee will be $3 a day until March 2017.

Next steps

Now that the transfer agreement has been signed, the next step is to ensure that everything moves smoothly towards the expected transfer on April 1, 2016.

The SAH Administration will continue to keep you informed as the transfer unfolds.

[APG]

No. 500-06-000952-180

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Defendants

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OF THE ATTORNEY GENERAL OF CANADA

EXHIBIT AGC-10

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O/Ref : 9683661 BC0565

THE RESIDENTS' NEWSLETTER
OF STE. ANNE'S HOSPITAL

May 2015 Number 1

The President's Corner

Dear comrades,

As President of your Residents' Committee, I am pleased to address a few words to you.

The primary objective of the newsletter that you are holding, whose formula has been revisited, is to provide you with information on relevant topics that matter to you, as Veterans of Ste. Anne's Hospital. You already have an example on this first page, which outlines an overview of the important information meeting which took place last April 29th.

The present formula will also focus on the many activities of your elected Residents' Committee, whose goal is to enhance your quality of life in a variety of ways. Since we know how much you appreciate it, you will still find stories on Veterans, under a section called "Our heroes tell their story".

This newsletter remains the product of collaboration between your Residents' Committee and various partners, who believe in the relevance of such a project and who support its realization, and I would like to thank them.

Since we want each Veteran to be given the opportunity to contribute to this project, we look forward to receiving your ideas and comments!

Mr. Stewart Vary
President

Signature of the transfer agreement of SAH: an important and long-awaited meeting!

It is in April 2015, after several years of negotiations, that the governments of Canada and Quebec sealed the agreement leading to the transfer of Ste. Anne's Hospital (SAH) under provincial jurisdiction. Following this signature, an important and highly anticipated information session was offered to the residents, clients and members of their families on April 29th, in the auditorium.

Here are the highlights that were communicated during this meeting:

• The anticipated date for the transfer is April 1, 2016. Should this timetable be postponed for administrative reasons, the Government of Quebec will notify us no later than November 2015.

• The Government of Canada will contribute funding for the enrichment of care and services offered at SAH after the transfer, so that each eligible Veteran will continue to receive exceptional care and services.

• The care and services will continue to be offered in French or English, as the Veteran prefers.

• Within a reasonable time frame following the transfer, civilians will be admitted to SAH. This will allow us to make the beds that are currently vacant available to citizens in need. However, eligible Veterans will be given priority access.

• A transition committee will be set up for a period of approximately three years following the date of the transfer, to ensure compliance of the conditions and obligations of the agreement, and to contribute to a smooth transfer of SAH to the Quebec healthcare network.

• Lieutenant-General (Retired) Michel Maisonneuve will sit on the committee as a representative for the Veterans. He has to his credit considerable military experience and excellent knowledge of SAH, as a member of the Board of Directors of our Foundation.

A more descriptive summary of the meeting will soon be made available on the care units for consultation by the residents and members of their families.

Here is a file to follow with great interest!

Executive Director's Message

Dear Veterans,

We have all come to realize, over the past year, the added value of a newsletter specifically intended to you, dear Veterans. That is why I welcome with great enthusiasm this decision of the Residents' Committee to keep alive the project of an information bulletin for the residents of Ste. Anne's Hospital, and it is with great delight that I will collaborate to this newsletter on a regular basis.

As a first contribution, I cannot do otherwise than come back to the latest breaking news: the recent signature of the agreement leading to the transfer of our establishment to the provincial authorities. I am aware that a change of this magnitude is not without generating concerns and anxiety, but rest assured that, in the coming months, we will continue to do our best to ensure that this transfer be as seamless as possible. We will also keep you informed on new developments on the subject.

It is my belief that the great family of Ste. Anne's Hospital, while fully opening up to the community, will proudly preserve what makes us who we are, and make this change a success. Our greatest source of pride has always been, and will remain, dear Veterans, to ensure you the best possible quality of life.

Have a wonderful springtime, and enjoy our landscaped gardens!

Rachel Corneille Gravel

Your Residents' Committee informs you...

In addition to representing you, the Veterans of SAH, and defending your rights, your Residents' Committee puts it all out in order to offer you a variety of activities with the common goal being unifying and improving your quality of life.

Here is a brief review of the activities recently presented, and others that will take place in the upcoming weeks:

Recent activities:
March 6 to 8: Residents' Committee Stand
March 28: Special Pub at the Auditorium
April 10: Ladies' Tea
April 30: Special annual assembly and Bingo
May 8: Distribution of flowers to the female residents on the occasion of Mothers' Day
May 16: Secretary-Treasurer, William Kane's presentation at the Royal Canadian Legion

Upcoming activities:
May 29: Residents' Committee Elections

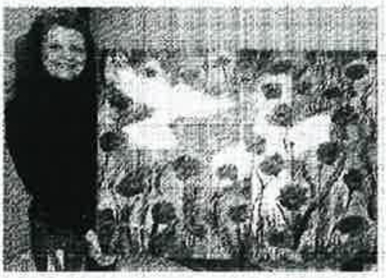
Ongoing activities:
Coffee and biscuits
(two afternoons per week at the Rendez-Vous)
Village Coffee (one Friday evening per month)
The Gazette newspaper
(available daily for consultation in the Library)

It is under the theme "Celebrating the arrival of spring" that the "Ladies' Tea" was offered to residents, clients of the Centre Liaison and their family members.

Gathered in the auditorium in a Spring decor and invited to wear vintage hats, the participants were able to enjoy a nice cup of tea accompanied by delicious cup cakes, in a festive atmosphere. In fact, the activity was enhanced by the *Glee Club* choir, composed of residents of our own institution, and under the skillful leadership of Mr. Erwin Hamilton, a Liaison Center client and Volunteer of SAH, and of Father Crisp, at the piano.

A big thank you to all present and to those whom without this activity would not be held!

A magnificent painting offered to the residents!



At the end of last January, as she was about to complete her journey at the Residential Treatment Clinic for Operational Stress Injuries (RTCOSI), a client expressed her wish to offer the residents of SAH one of her own paintings, realized during her passage with us. This generous person is Mrs. Leslie Ferguson, a New Brunswick native, who followed a stabilization and residential program at RTCOSI for slightly more than three months.

This former criminal intelligence analyst – National Security Division, within the Royal Canadian Mounted Police – was preparing to return among her family, in Ottawa, when a member of the Communications and Commemoration Directorate met with her to accept her donation. Inspiring, she confided that it was thanks to the therapeutic program of RTCOSI that she had regained her creativity and taken up painting again, a hobby that she had abandoned for some time now. As the days passed at SAH, she asserted that she had recovered her self-esteem, her dignity and her capacity to tell herself "I can do it again".

"The Veterans, both young and old, have done so much for me that this canvas cannot be installed anywhere else but here", indicated Mrs. Ferguson.

You can admire the piece of art by going to the corridor leading to the Edith-Temple Pavilion, near the auditorium.

Outpouring of generosity by the Royal Canadian Legion branches

On behalf of all the Veterans residing in our establishment, the Residents' Committee of SAH would like to thank the different branches of the Royal Canadian Legion for such generosity towards them. Indeed, in the last months, several donations have been received which will help to finance a range of different activities.

Branches who made a donation in 2014-2015:
Arvida, no. 209; Auclair, no. 121; Ayer's Cliff, no. 128; Bay Chaleur, no. 172; Beauharnois, no. 146; Churchill, no. 91; Coquelicot, no. 56; Cowansville, no. 99 (Poppy Fund); Frederick Kisch, no. 97; Jubilée, no. 59; La Tuque, no. 31; Mount Sorrel, no. 64; Norris, no. 227; Quebec Command; Rocher Percé, no. 261; Rosemount, no. 29; Val d'Or, no. 76.

Donation of fifty "polar" type vests!

Mr. Peter Kuzik, an individual from Sainte-Anne-de-Bellevue, displayed tremendous generosity when he donated fifty "polar" type vests, intended for the residents and clients of RTCOSI. Mr. Raymond Meloche, a resident on the 8th floor, had an array of choices when he took possession of his new clothing, accompanied by Mrs. Johanne Grenier, manager of the Volunteer Services of SAH.

A school project for the benefit of the Veterans of SAH!

The residents of the Remembrance Pavilion had a wonderful surprise on the occasion of Valentine's Day. Indeed, the students of primary school Brind'Amour, in Vaudreuil-Dorion, concluded a long-term school project by delivering no less than 120 stuffed animals to as many Veterans of our establishment.

This social value project was incorporated within the "community aspect" of this teaching institution, an approach promoting in particular the reinforcement link between the students and their community. By doing so, the child has a greater awareness of the impacts of his lifestyle on himself, others and the environment.

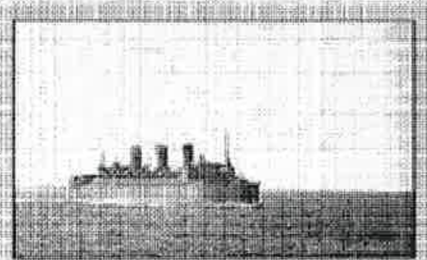
Pierre Gariépy, a resident of care unit 2B, accompanied by his spouse, Joyce Simmons. He seemed overwhelmed by the generosity of this group of students.

Our heroes tell their story

Paul-Émile Lamouche – 11th floor resident

Montrealer Paul-Émile Lamouche has mixed emotions when the postman brings a letter, signed by Prime Minister Mackenzie King, announcing the recruitment of young men aged 18 years and older. Faced with mandatory military service, young Mr. Lamouche leaves a position as inspector with *RCA Victor* and enlists in 1943. His six months of training takes place in Sorel, Valcartier and Debert (Nova Scotia). A first jump, more or less successful, rapidly makes him put aside the paratrooping team, and instead, he joins the infantry within the Royal 22nd Regiment.

It is accompanied by thousands of soldiers that he crosses the Atlantic, aboard the ship "Île de France". His baptism of the sea is painful since the majority of his time is spent lying in a hammock with severe seasickness! Following a brief training course in England, he resumes his voyage, this time within a convoy of ten corvettes, towards Naples, in Italy. Before disembarking, he receives valuable advice: "Keep everything that you have for yourself, when you are in the battlefront. You will need it!"



The ship 'Ile-de-France' sailing towards Europe

In 1944, intense fighting is taking place, and soldier Lamouche narrowly escapes death on some occasions, as well as witnessing unspeakable atrocities. One day, renowned lieutenant Harry Pope approaches the platoon of our hero for assistance in recuperating two wounded men on the battlefield. Lamouche and another soldier are designated and rapidly execute. On May 19, our Veteran is captured by the Germans near Monte Cassino. From there, the prisoners march towards Aquino where they are placed in trains heading to Munich. During one of these transits, Lieutenant Pope escapes from a German truck in motion. The consequence is cruel, since the Nazis immediately put chains on the feet of the prisoners. Mr. Lamouche will suffer for a long time...

The young soldier Lamouche during his convalescence, in England

On his arrival in Germany, our courageous soldier is committed to *Stalag VIIA*, a building complex surrounded by barbed wire, and is forced to clean the scenes of multiple carnages. After 336 long days, he is finally liberated by the Americans, on April 29, 1945, and flown to Belgium. Shortly after, he is transferred to England where he stays for two months, the time it takes to heal multiple skin infections caused by the chains of the Nazis. He finally returns to the country aboard a Red Cross ship.

Returning to civilian life, he shares his professional career between *RCA Victor* and *Hoffman Laroche*, a pharmaceutical business, where he oversees receipts/shipments. Today, at 91, this former Liaison Centre client has resided at SAH for nearly four years, and enjoys a peaceful existence playing bingo, bowling and dancing.

Grateful for surviving the war, this father of one daughter has always had deep admiration for Brother André whom he claims helped him get back to normal life.

Your Residents' Committee:

Stuart Vary (President)
Charles Bussières (Vice-President)
Hormidas Larivière et Roger Blais (Directors)
William Kane (Secretary-Treasurer, Legion Representative)
Yves Grisé (Volunteers Representative)

No. 500-06-000952-180

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EXHIBIT AGC-11

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Centre intégré
universitaire de santé
et de services sociaux
de l'Ouest-de-
l'Île-de-Montréal
Québec
Bureau du président-directeur général

PAR COURRIER ÉLECTRONIQUE

Pointe-Claire, le 14 décembre 2015

Madame Rachel Corneille Gravel
Directrice générale
Hôpital Sainte-Anne
305, boulevard des Anciens-Combattants
Sainte-Anne-de-Bellevue (Québec) H9X 1Y9

Objet : Suivi de la rencontre du 25 novembre 2015

Madame la Directrice générale,

Dans le cadre de notre rencontre du 25 novembre dernier, vous nous avez soumis des points de préoccupation qui étaient actuellement soulevés par les employés de votre établissement en lien avec la présente transition. Nous nous étions engagés à vous répondre rapidement afin que les différentes étapes à venir puissent être réalisées de la façon la plus harmonieuse possible. La présente constitue ce suivi.

Vous avez d'abord soulevé la question entourant l'appariement des emplois liés à l'hygiène et la salubrité, plus spécifiquement dans l'attribution du titre d'emploi de préposé à l'entretien ménager lourd versus préposé à l'entretien ménager léger. Tel qu'alors indiqué, suite à cette rencontre, nous sommes en réflexion à ce sujet dans un contexte de standardisation et d'équité au sein du Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal (ci-après CIUSSS).

Il a ensuite été question de la situation de certains professionnels qui semblent se sentir lésés au niveau des salaires attribués dans les offres d'emploi. Après vérifications, nous comprenons que les offres sont respectueuses de l'entente signée entre les différentes instances gouvernementales, que nous devons appliquer à ce stade-ci du transfert. Nous comprenons également que ces professionnels, comme tous les employés de l'établissement, conservent d'autres avantages découlant de l'application de cette entente. Il va de soi que nous souhaitons conserver les expertises au sein de l'Hôpital Sainte-Anne, mais dans le respect des règles convenues.

Passons maintenant à la reconnaissance de l'atout distinctif pour les employés d'avoir de l'expérience de travail auprès de la clientèle de l'Hôpital Sainte-Anne. Vous nous avez alors mentionné que suivant le 1er avril, certains préposés aux bénéficiaires aimeraient potentiellement

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être réembauchés par le CIUSSS pour travailler de nouveau à l'Hôpital Sainte-Anne. Actuellement, le CIUSSS, parmi ses critères d'embauche pour les préposés aux bénéficiaires, requiert d'avoir complété avec succès le diplôme d'études professionnelles en assistance à la personne en établissement de santé. Nous comprenons que vos processus et critères d'embauche sont différents. Dans ces circonstances, spécifiquement pour un ancien préposé aux bénéficiaires de l'Hôpital Sainte-Anne qui désire y retravailler, nos exigences reliées à la formation seraient les suivantes :

- Diplôme d'études professionnelles (DEP – Assistance à la personne en établissement de santé);

ou

- Diplôme d'études secondaires V avec 2 ans d'expérience à titre de préposé(e) aux bénéficiaires à l'Hôpital Sainte-Anne;

et

- Réussite d'un test de RCR et PDSB.

Il est à noter que ces exigences pourraient être amenées à changer dans le temps, compte tenu des besoins évolutifs de la clientèle ou des documents normatifs applicables.

Finalement, en ce qui a trait à l'application de la prime de psychiatrie et congés mobiles, cette question doit être traitée dans le cadre des négociations nationales et n'est pas du ressort des établissements du réseau.

Nous souhaitons que ce suivi permettra d'appuyer la progression de la présente transition afin d'assurer la continuité des soins de qualité aux clients de l'Hôpital Sainte-Anne.

Veuillez agréer, madame la Directrice générale, nos sentiments les meilleurs.

Le président-directeur général,

Benoît Morin, PhD, MBA

c. c. : Mme Michèle Gauthier, directrice des ressources humaines, des communications et des affaires juridiques, CIUSSS de l'Ouest-de-l'Île-de-Montréal

No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

WOLF WILLIAM SOLKIN

Plaintiff

vs.
THE ATTORNEY GENERAL OF CANADA
-and-
THE ATTORNEY GENERAL OF QUEBEC
-and-
THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

LIST OF EXHIBITS AGC-1 TO AGC-25
IN SUPPORT OF THE DEFENCE
OF THE ATTORNEY GENERAL OF CANADA

EXHIBIT AGC-12

Attorney General of Canada

Department of Justice Canada
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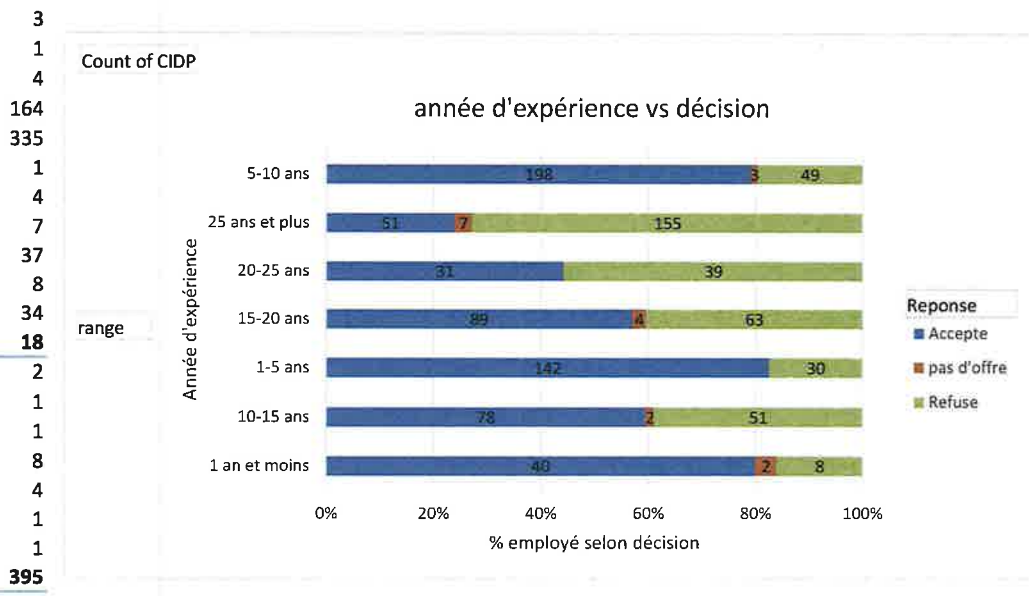
O/Ref : 9683661 BC0565

AGC-13

Count of CIDP	Column Labels		
Row Labels	Determinate	indeterminate	Grand Total
Accepte	**200**	**429**	**629**
Bibliothécaire		1	1
Chauffage, force mot, opération mach fixe		2	2
Économiste -Service social		5	5
Ergothérapie et physiothérapie		7	7
Finance		1	1
Gestion ressources humaines		2	2
Informatique	1		1
Ingénieur		1	1
Manœuvre - Personnel de métier		6	6
Nutrition et Diététique	1	4	5
Pharmacie		3	3
Programme de bien-être social		1	1
Psychologie		4	4
Sciences infirmières	47	117	164
Serv ménager, diététique, hôpital malade	112	223	335
service d'information		1	1
Service Social	1	3	4
Services Administratifs	2	5	7
Soutien administratif	13	24	37
Technicien divers	3	5	8
Technicien laboratoire ou autre	20	14	34
pas d'offre	**1**	**17**	**18**
Cadre de direction		2	2
Finance		1	1
Gestion ressources humaines		1	1
Médecine	1	7	8
Serv ménager, diététique, hôpital malade		4	4
service d'information		1	1
Soutien administratif		1	1
Refuse	**54**	**341**	**395**
Achats et approvisionnement		1	1

Count of CIDP	Column Labels			
Row Labels	Accepte	pas d'offre	Refuse	Grand Total
1 an et moins	40	2	8	50
10-15 ans	78	2	51	131
1-5 ans	142		30	172
15-20 ans	89	4	63	156
20-25 ans	31		39	70
25 ans et plus	51	7	155	213
5-10 ans	198	3	49	250
Grand Total	**629**	**18**	**395**	**1042**



Ergothérapie et physiothérapie		8	8
Finance		2	2
Gestion ressources humaines		4	4
Informatique		4	4
Manœuvre - Personnel de métier		6	6
Nutrition et Diététique		3	3
Pharmacie		1	1
Programme de bien-être social		3	3
Psychologie		4	4
Sciences infirmières	5	82	87
Serv ménager, diététique, hôpital malade	37	151	188
Service Social	1	2	3
Services Administratifs		14	14
Soutien administratif		38	38
Technicien divers	1	4	5
Technicien laboratoire ou autre	10	14	24
Grand Total	**255**	**787**	**1042**

No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

WOLF WILLIAM SOLKIN

Plaintiff

vs.
THE ATTORNEY GENERAL OF CANADA
-and-
THE ATTORNEY GENERAL OF QUEBEC
-and-
THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

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IN SUPPORT OF THE DEFENCE
OF THE ATTORNEY GENERAL OF CANADA

EXHIBIT AGC-13

Attorney General of Canada

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O/Ref : 9683661 BC0565

AGC-14

Ministère de la Santé
et des Services
sociaux
Québec
Bureau du sous-ministre

PAR COURRIER ÉLECTRONIQUE

Québec, le 11 janvier 2016

Monsieur Walter Natynczyk
Sous-ministre
Anciens combattants du Canada
161, rue Grafton, pièce 405
Case postale 7700
Charlottetown (Île-du-Prince-Édouard) C1A 8M9

Monsieur le Sous-ministre,

À la suite de la signature de l'Entente de cession, la province de Québec a obtenu l'autorisation d'accéder aux installations de l'Hôpital Sainte-Anne (HSA) afin de se préparer à la prise en charge de la gestion, de l'exploitation et de l'entretien de l'HSA par le Centre intégré universitaire de santé et de services sociaux (CIUSSS) de l'Ouest-de-l'Île-de-Montréal. Par conséquent, le CIUSSS de l'Ouest-de-l'Île-de-Montréal a mandaté une firme pour procéder à l'inspection technique des bâtiments de l'HSA.

Nous avons pris connaissance du rapport final d'inspection et comparé les résultats obtenus avec le rapport d'inspection que vous nous avez transmis lors des négociations, rapport qui était daté de 2010. Nous avons constaté que la plupart des travaux identifiés urgents et prioritaires n'ont pas été réalisés, de sorte que le CIUSSS aurait à intégrer l'HSA avec une valeur diminuée par ce défaut d'entretien des installations.

À cet égard, les travaux à faire inscrits au plan de maintien des actifs sont évalués à 67,6 M$ dans un horizon de cinq ans et le CIUSSS a évalué à 16,3 M $ les travaux urgents et prioritaires à réaliser dès l'année 2016 pour assurer la sécurité des bâtiments et la prestation sécuritaire de soins. Vous trouverez en annexe à la présente le détail de ces montants.

. . . 2

Québec
1075, chemin Sainte-Foy, 14e étage
Québec (Québec) G1S 2M1
Téléphone : 418 266-8989
Télécopieur : 418 266-8990

En conséquence, nous vous saurions gré de faire réaliser les travaux urgents avant la cession de l'HSA au Québec ou alors de vous engager à les rembourser au CIUSSS afin qu'ils soient réalisés dès 2016.

Veuillez agréer, Monsieur le Sous-ministre, l'expression de nos sentiments les meilleurs.

Le sous-ministre,

Michel Fontaine

p. j. Coûts critiques, Coûts critiques sommaire et Plan de maintien d'actifs

c. c. M. Gaétan Barrette, ministre de la Santé et des Services sociaux
M. Benoît Morin, CIUSSS de l'Ouest-de-l'Île-de-Montréal

N/Réf. : 16-MS-00030

Veterans Affairs Canada | Anciens Combattants Canada
Deputy Minister | Sous-ministre

Monsieur Michel Fontaine
Sous-ministre
Ministère de la Santé et des Services sociaux du Québec
1075, chemin Sainte-Foy, 14e étage
Québec (Québec) G1S 2M1

Objet : **Réponse à une demande de travaux urgents à réaliser à l'Hôpital Sainte-Anne**

Monsieur le Sous-ministre, Michel,

Nous accusons réception de votre lettre, datée du 11 janvier 2016, dans laquelle vous indiquez que des travaux identifiés comme étant urgents et prioritaires, dans un rapport d'inspection remontant à 2010, n'ont, à ce jour, pas été réalisés par l'Hôpital Sainte-Anne (HSA).

Par conséquent, vous demandez dans votre lettre que les travaux urgents soient réalisés avant la date de cession de l'HSA, prévue le 1er avril 2016, ou que le gouvernement fédéral s'engage à verser un montant de 16,3 M$ au Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal (CIUSSS ODIM) afin que celui-ci effectue ces travaux dès 2016. Vous avez aussi indiqué par la suite que le CIUSSS ODIM ne procéderait pas au recrutement du personnel nécessaire au bon fonctionnement de l'HSA après le 1er avril 2016, et ce, jusqu'à ce que votre demande soit acceptée.

Toutefois, au cours d'un entretien téléphonique tenu le 28 janvier 2016, vous avez confirmé que, après un examen plus approfondi, un montant de $9,8M versé au CIUSSS ODIM répondrait à votre demande. Il a également été convenu que, lors de la confirmation que votre demande de fonds est satisfaite, le recrutement du personnel commencerait immédiatement.

.../2

La présente confirme que le Gouvernement du Canada versera un montant de $9,8M au CIUSSS ODIM dès la date de cession. Cette offre de paiement est conditionnelle à ce que la date de cession du 1 avril 2016 soit respectée, que le CIUSSS ODIM reprenne immédiatement le plan de recrutement mis de l'avant et que le Gouvernement du Québec et le CIUSS ODIM ne fassent plus de demandes additionnelles de fonds ou de travaux.

Anciens Combattants Canada prévoit que cette initiative va de l'avant, tout en respectant l'Entente de cession négociée de bonne foi. Notre plus grande préoccupation reste le soin continu de nos anciens combattants.

Veuillez agréer, monsieur le Sous-ministre, l'expression de mes sentiments les meilleurs.

W.J. Natynczyk
Général (à la retraite)
Sous-ministre

c.c. Les Linklater, Sous-secrétaire du Cabinet
Yaprak Baltacioglu, Secrétaire du Conseil du Trésor du Canada
Bill Pentney, Sous-ministre de la Justice, et Sous-procureur général du Canada
Paul Rochon, Sous-ministre, Finance

Ministère de la Santé
et des Services
sociaux
Québec
Bureau du sous-ministre

PAR COURRIER ÉLECTRONIQUE

Québec, le 1er février 2016

Monsieur Walter J. Natynczyk
Sous-ministre
Anciens combattants du Canada
161, rue Grafton, pièce 405
Case postale 7700
Charlottetown (Île-du-Prince-Édouard) C1A 8M9

Monsieur le Sous-Ministre,

À la suite de votre lettre reçue le 29 janvier dernier, nous vous confirmons que le ministère de la Santé et des Services sociaux accepte votre proposition de verser au Centre intégré universitaire de Santé et de Services sociaux (CIUSSS) de l'Ouest-de-l'Île-de-Montréal la somme de 9,8 M$, au plus tard à la date de cession le 1er avril 2016, et ce, afin que soient effectués les travaux identifiés urgents aux installations de l'Hôpital Sainte-Anne (HSA).

En conséquence de ce qui précède, le CIUSSS de l'Ouest-de-l'Île-de-Montréal entame dès maintenant le processus de dotation pour réaliser la cession de l'HSA avec diligence à la date convenue, soit le 1er avril 2016.

Veuillez agréer, Monsieur le Sous-Ministre, l'expression de nos sentiments les meilleurs.

Le sous-ministre,

Michel Fontaine

c. c. Benoît Morin, CIUSS de l'Ouest-de-l'Île-de-Montréal
Mme Lynne McVey, CIUSSS sociaux de l'Ouest-de-l'Île-de-Montréal

N/Réf. : 15-MS-00030-02

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No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

WOLF WILLIAM SOLKIN

Plaintiff

vs.

THE ATTORNEY GENERAL OF CANADA

-and-

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-and-

THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

LIST OF EXHIBITS AGC-1 TO AGC-25
IN SUPPORT OF THE DEFENCE
OF THE ATTORNEY GENERAL OF CANADA

EXHIBIT AGC-14

Attorney General of Canada

Department of Justice Canada
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O/Ref : 9683661 BC0565

NOTE DE SERVICE / MEMORANDUM – TRANSITION

À / TO : Résidents et familles / Patients and families
DE / FROM : Directrice générale / Executive Director
DATE : 24 mars 2016 / March 24, 2016

OBJET / SUBJECT : SERVICES DE COIFFURE ET DE BARBIER / HAIRDRESSING AND BARBER SERVICES

Bonjour,

Nous sommes heureux de vous informer que le ministère des Anciens Combattants assumera les frais liés aux services de coiffure et de barbier offerts à l'Hôpital Sainte-Anne après le 1er avril 2016.

Ainsi, ces services continueront à être offerts aux résidents gratuitement.

****

Hello,

We are pleased to inform you that the Department of Veterans Affairs will assume the costs related to the hairdressing and barber services offered at Ste. Anne's Hospital after April 1, 2016.

Therefore, these services will continue to be provided to the residents free of charge.

Rachel Corneille Gravel
Directrice générale de l'HSA

No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

WOLF WILLIAM SOLKIN

Plaintiff

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-and-

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THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

LIST OF EXHIBITS AGC-1 TO AGC-25
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OF THE ATTORNEY GENERAL OF CANADA

EXHIBIT AGC-15

Attorney General of Canada

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Canad

Cabinet du ministre

POUR DIFFUSION IMMÉDIATE
Code de diffusion CNW 01

Le gouvernement du Canada cède officiellement l'Hôpital Sainte-Anne au réseau de la santé et des services sociaux du Québec

Québec, le 30 mai 2016 – Le ministre de la Santé et des Services sociaux, monsieur Gaétan Barrette, le ministre responsable des Affaires autochtones et député de Jacques-Cartier, monsieur Geoffrey Kelley, le ministre des Anciens Combattants et ministre associé de la Défense nationale, l'honorable Kent Hehr ainsi que le député fédéral de Lac-Saint-Louis, monsieur Francis Scarpaleggia, ont annoncé aujourd'hui la cession officielle de l'Hôpital Sainte-Anne (HSA) au réseau de la santé et des services sociaux du Québec.

Jusque-là propriété du ministère des Anciens Combattants du Canada, l'HSA a été cédé au CIUSSS de l'Ouest-de-l'Île-de-Montréal par le biais d'une transaction entre les deux gouvernements qui a pris effet le 1er avril 2016. L'HSA aura la mission de centre d'hébergement de soins de longue durée. L'entente officialisant la transaction prévoit un accès prioritaire aux anciens combattants.

Utilisation des lits disponibles à l'HSA

« L'Hôpital Sainte-Anne, qui compte 446 lits, accueille de la clientèle civile provenant des territoires de Montréal et de la Montérégie. Tout en maintenant les soins et services aux anciens combattants, nous allons maximiser les espaces disponibles, et utiliser l'expertise de l'HSA pour répondre aux besoins de plusieurs clientèles. Nous sommes heureux que ce transfert soit un bel exemple d'une collaboration fédéral-provincial et ce, au bénéfice des patients du Québec », a déclaré monsieur Barrette.

Les lits de l'HSA seront utilisés comme suit :
- La clientèle des anciens combattants
- 32 lits d'hébergement pour la région de la Montérégie, et éventuellement 128 lits seront disponibles pour cette région
- 96 lits provenant de l'installation Grace Dart à l'automne 2016
- Par la suite, les autres lits seront dédiés à la région de Montréal

« Il était important pour Anciens Combattants Canada et le gouvernement du Québec que ce transfert se déroule de la façon la plus harmonieuse possible pour les vétérans et les employés. Nous voulions minimiser les répercussions pour ceux et celles qui ont besoin de soins et pour ceux et celles qui fournissent ces soins. La collectivité locale bénéficiera de l'expertise distincte de l'Hôpital Sainte-Anne en matière de prestation de soins de longue durée aux vétérans. C'est une excellente nouvelle pour la région. Il convient toutefois de préciser que tous les vétérans admissibles continueront d'avoir une priorité d'accès aux soins et aux services exceptionnels de l'Hôpital Sainte-Anne, et que le Ministère continuera de travailler en étroite collaboration avec le gouvernement du Québec pour s'assurer que les vétérans qui ont servi notre pays reçoivent le support et les soins dont ils ont besoin et méritent», a déclaré le ministre Hehr.

Le personnel de l'HSA

Une période de recrutement de personnel a eu lieu en vue de pourvoir aux postes disponibles à la suite des départs à la retraite des employés de l'HSA. Quant aux employés de l'HSA ayant accepté une offre d'emploi du CIUSSS, ils auront les conditions de travail en vigueur dans le réseau de la santé et des services sociaux du Québec. Ainsi, l'HSA conserve son expertise en gériatrie, au bénéfice de l'ensemble de ses résidents.

Les étapes à venir

Notons que l'accueil des premiers nouveaux résidents de la région de la Montérégie à l'HSA a débuté depuis le 15 avril dernier, et se poursuivra jusqu'au 30 septembre 2016 avec l'arrivée des patients transférés de Grace Dart. Le CIUSSS de l'Ouest-de-l'Île-de-Montréal est responsable de la planification, de la préparation et de l'opérationnalisation de cette transition. L'objectif est d'allier l'expertise déjà en place et les nouvelles pratiques, avec la vague de nouveaux employés qui arriveront, de manière à proposer à la clientèle une offre de service des plus optimales.

Le ministre Geoffrey Kelley a quant à lui ajouté : « L'HSA a été rénové il y a quelques années. Il s'agit donc d'une installation modernisée, de qualité, ce qui sera avantageux à la fois pour les personnes âgées qui y reçoivent des soins, et pour le personnel clinique. Je suis persuadé que l'HSA continuera à être reconnu pour sa grande qualité en matière de gériatrie et de psychogériatrie, et cela, au bénéfice des patients et des usagers ».

Enfin, le ministre Barrette a conclu : « Il s'agit d'une excellente nouvelle pour les régions de la Montérégie et de Montréal. Utiliser l'HSA pour développer dès maintenant plusieurs nouvelles places en hébergement aura assurément des effets positifs sur les réseaux des deux régions. De plus, ce nouveau milieu, qui permettra de libérer des lits d'hôpitaux occupés par des patients dont les soins actifs sont terminés, aura pour effet d'améliorer l'accès pour les patients en attente d'une hospitalisation, que ce soit en chirurgie ou en médecine ».

- 30 –

Renseignements : Julie White
Attachée de presse du ministre de la Santé
et des Services sociaux
418 266-7171

Sarah McMaster
Attachée de presse du ministre des Anciens Combattants et ministre associé à la Défense nationale
613 996-4649

No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

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Plaintiff

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Defendants

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EXHIBIT AGC-16

Attorney General of Canada

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O/Ref : 9683661 BC0565

AGC-17

Ministère de la Santé
et des Services
sociaux
Québec

Direction générale des finances,
des infrastructures et du budget

PAR COURRIER ÉLECTRONIQUE
CONFIDENTIEL

Québec, le 6 juin 2016

Madame Elizabeth Stuart
Sous-ministre adjointe
Ressources humaines et services ministériels
Anciens Combattants Canada
CP 7700
Charlottetown (Île du-Prince-Édouard) C1A 8M9

Objet : Ajustement des *per diem* prévus à l'Entente de cession

Madame la Sous-Ministre adjointe,

En suivi de la lettre du 26 février 2016, nous souhaitons vous confirmer le taux du per diem pour l'année 2016-2017 et vous informer de la méthode de paiement du per diem médical, lequel sert à rémunérer la présence médicale à l'Hôpital Sainte-Anne (HSA).

Le taux d'accroissement des centres d'hébergement et de soins de longue durée est établi à 1,26 % pour l'année 2016-2017. Le per diem applicable à partir du 1er avril 2016 est donc de 144,89 $. Par ailleurs, nous vous informons que la contribution de l'usager pour cette année est de 19,63 $. Le Centre intégré universitaire de santé et de services sociaux (CIUSSS) de l'Ouest-de-l'Île-de-Montréal procèdera à l'émission d'une nouvelle facture concernant cet ajustement.

Comme vous le savez et comme discuté dans le cadre de la négociation de l'Entente de cession de l'HSA, le statut des médecins au Québec est celui de travailleur autonome. L'organisme provincial chargé de l'administration des honoraires des médecins est la Régie de l'assurance maladie du Québec (RAMQ). En conséquence, le paiement du per diem médical doit être fait à la RAMQ. Puisque l'implication du CIUSSS de l'Ouest-de-l'Île-de-Montréal est également nécessaire dans le cadre de l'établissement du montant payable mensuellement, en lien avec le nombre d'anciens combattants à l'HSA, le ministère de la Santé et des Services sociaux (MSSS) a, en collaboration avec le CIUSSS de l'Ouest-de-l'Île-de-Montréal et la RAMQ, défini la procédure à suivre pour le paiement du per diem présence médicale.

... 2

1075, chemin Sainte-Foy, 16e étage
Québec (Québec) G1S 2M1
Téléphone : 418 266-5965
Télécopieur : 418 266-2248
Courriel : francois.dion@msss.gouv.qc.ca

Voici les responsabilités respectives convenues :

1- La RAMQ reçoit mensuellement du CIUSSS de l'Ouest-de-l'Île-de-Montréal le rapport des lits occupés par jour par des anciens combattants et la liste des résidents anciens combattants hébergés;
2- La RAMQ facture le per diem médical à Anciens Combattants Canada;
3- Le paiement est fait à l'ordre de la RAMQ.

Des indications plus précises et les coordonnées des différents intervenants vous seront acheminées par les membres de mon équipe.

Finalement, nous tenons à rappeler que le per diem présence médicale sera facturé au montant de 7,01 $ par ancien combattant hébergé, et cela, jusqu'à ce que l'interprétation de la clause de l'entente soit acceptée par Anciens Combattants Canada ou qu'un tiers saisi de la question ait rendu une décision à cet égard. Nous rappelons que la prétention du MSSS est que le coût réel de la présence médicale excédant celui de nos établissements provinciaux est entièrement à votre charge. Sachez que nous sommes ouverts à réviser, si vous le souhaitez, les modalités de la présence médicale à maintenir à l'HSA, si vous estimez le coût de la mesure trop élevé.

Veuillez agréer, Madame la Sous-Ministre adjointe, l'expression de nos sentiments les meilleurs.

Le sous-ministre adjoint,

François Dion, CPA, CA

c. c. Mme Faith McIntyre, Anciens Combattants Canada
M. Nelson Fortier, Régie de l'assurance maladie du Québec
M. Philippe Matteau, Régie de l'assurance maladie du Québec
M. Benoît Morin, Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal
Mme Lynne McVey, Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal

N/Réf. : 16-FI-00055-10

No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

WOLF WILLIAM SOLKIN

Plaintiff

vs.

THE ATTORNEY GENERAL OF CANADA

-and-

THE ATTORNEY GENERAL OF QUEBEC

-and-

THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

LIST OF EXHIBITS AGC-1 TO AGC-25
IN SUPPORT OF THE DEFENCE
OF THE ATTORNEY GENERAL OF CANADA

EXHIBIT AGC-17

Attorney General of Canada

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O/Ref : 9683661 BC0565

Fiche de proposition de mandat

Titre du mandat :	PROJET PILOTE – Comité conjoint ACC/CIUSSS
Responsable du mandat (mandant) :	Lydia Ingenito, directrice adjointe des services de proximité, du continuum et de l'approche adaptée
Direction :	SAPA

Contexte et description du mandat

Le plan de fin de transition arrive à échéance dans quelques mois. Nos deux instances (ACC et CIUSSS) sont en réflexion pour déterminer par quel mécanisme nous pouvons assurer la pérennité des actions relatives au volet opérationnel.
Considérant les comités actuels à HSA :
- Comité des résidents
- Comité des vétérans
- Comité milieu de vie
- Comité local d'amélioration continue de la qualité
- La mise sur pied de ce nouveau comité doit se distinguer par son mandat, ses objectifs et ses moyens afin de répondre adéquatement à la clientèle cible et ses besoins. La création de ce comité par l'entremise d'un projet pilote sera réévalué dans un an.
Ce comité relèvera de la Direction SAPA.
Il est proposé de tenir une rencontre par saison.
Un ordre du jour ainsi qu'un compte rendu sera rédigé à chaque rencontre.

Mandat du comité :	**Assurer les suivis nécessaires concernant le bien-être des vétérans et de leurs familles à l'Hôpital Sainte-Anne, et proposer des recommandations conjointes et collaboratives au comité de transition visant à apporter des solutions novatrices.**

Objectifs du mandat :

1. Proposer des idées et ou des solutions suite à des enjeux ou situations particulières.
2. Faire des recommandations ou émettre des avis sur une situation au comité de transition
3. Contribuer avec les moyens mis à sa disposition à la réalisation de projets issus des recommandations ou des autres comités déjà en place à HSA.
4. Faire état au comité de transition des suivis concernant le bien-être des vétérans et de leurs familles.

Membres du comité

ACC :	CIUSSS ODIM :	MSSS :
▪ Directrice générale des opérations en région (Maryse Savoie) ; ▪ Directrice des programmes de soins de santé, gestion des programmes et de la prestation des services (Sandra Williamson) ; ▪ Gestionnaire de programme et agente de liaison aux établissements de soins de longue durée (Allison Thompson) ; ▪ Agente de liaison (Manuela Fonseca).	▪ Directeur du programme de soutien à l'autonomie des personnes âgées (Patrick Murphy-Lavallée) ; ▪ Directrice adjointe de l'hébergement (Marie-France Bodet) ; ▪ Coordonnatrice des services d'hébergement HSA (Martine Daigneault) ; ▪ Une gestionnaire de HSA (Isabelle Labrie) ; ▪ Un représentant de la DRHCAJ (au besoin).	▪ Directrice générale adjointe des services sociaux et des services aux aînés (Natalie Rosebush).

Suivi :

➢ Recommandations du comité conjoint au comité de transition.

No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

WOLF WILLIAM SOLKIN

Plaintiff

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-and-

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THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

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EXHIBIT AGC-18

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O/Ref : 9683661 BC0565

Veterans Affairs Canada | Anciens Combattants Canada
Deputy Minister | Sous-ministre

AGC-19

NOV 0 3 2016

Michel Fontaine
Sous ministre
Santé et Services sociaux
1075, chemin Sainte-Foy, 14e étage
Québec (Québec) G1S 2M1

Monsieur Fontaine, Cher Michel,

Cela fait maintenant six mois que le Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal (CIUSSS ODIM) a pris en charge la gestion de l'Hôpital Sainte-Anne (l'Hôpital). Depuis ce temps, nous avons reconnu les efforts positifs et la volonté de votre ministère de maintenir la qualité des soins et services offerts aux anciens combattants hébergés à l'Hôpital. Nous sommes aussi conscients des défis auxquels vous faites face en cette période de transition et nous reconnaissons pleinement vos efforts pour les surmonter.

Au cours des derniers mois, nos ministères ont fait preuve d'un grand esprit de coopération. Les deux rencontres réussies du Comité de transition, l'achèvement du volet de la technologie de l'information, et la continuation des services alimentaires à l'aide des offres à commande utilisées par Anciens Combattants Canada (ACC) en sont quelques exemples.

Cependant, des préoccupations quant à la stabilité et la continuité du personnel à l'Hôpital ont été portées à mon attention par les résidents et leurs familles. Ces préoccupations ont même été renforcées dans une lettre adressée aux membres du Comité de transition par la Fédération interprofessionnelle de la santé du Québec (FIQ) (voir la pièce jointe). Il semblerait que ces problèmes aient affecté la qualité des soins et services offerts depuis le transfert, et ceci malgré la présence médicale 24/7. Cela étant dit, nous reconnaissons les défis auxquels vous faite face dans le recrutement du personnel et on m'a informé que la situation s'améliore de façon graduelle.

.../2

On m'a aussi fait part des préoccupations des résidents et de leurs familles concernant l'admission des civils à l'Hôpital. Ils craignent que cela puisse exacerber la situation actuelle puisque le personnel déjà en manque doit maintenant gérer une charge de travail plus lourde. De sorte à sécuriser leurs préoccupations quant à la qualité des soins et services qui leurs sont offerts, nous vous prions de traiter cette question avec la plus haute priorité.

Je vous demanderais donc que ces sujets reçoivent une attention prioritaire lors de la prochaine rencontre du Comité de transition qui aura lieu au mois de décembre.

Enfin, pour traiter et apaiser les préoccupations concernant la qualité des soins et services ainsi que pour renforcer les liens entre nos ministères et encourager une coopération continue, nous vous proposerons lors de la rencontre du Comité de transition en décembre d'ouvrir un bureau sur place à l'Hôpital qui serait composé d'un cadre de personnel d'ACC. Ce bureau, qui n'aurait ni une présence imposante ni permanente, tisserait un lien important avec l'Établissement et saurait assurer les résidents anciens combattants et leurs familles du dévouement d'ACC à leur égard, surtout en ce qui a trait à la qualité des soins et services.

Notre engagement envers nos anciens combattants demeure de première importance. Nous veillerons toujours à ce qu'ils reçoivent les soins et les services exceptionnels auxquels ils ont droit, et cela dans la langue officielle de leur choix.

Veuillez agréer, Monsieur Fontaine, l'expression de mes sentiments distingués.

W.J. Natynczyk
Général (à la retraite)
Sous-ministre

Pièce jointe :

1) Lettre de l'Exécutif syndical des Professionnels en Soins de la Santé Unies (PSSU) de l'Hôpital Sainte-Anne affilié à la Fédération interprofessionnelle de la santé du Québec (FIQ)

FIQ Montréal

FIQ Québec

FÉDÉRATION INTERPROFESSIONNELLE DE LA SANTÉ DU QUÉBEC

Sainte-Anne-de-Bellevue, le 11 octobre 2016

Comité transitoire de la cession de l'Hôpital Sainte-Anne
Lieutenant-Général Michel Maisonneuve
Ministère des Anciens Combattants Canada
Monsieur le sous-ministre Michel Fontaine
Ministère de la Santé et des Services sociaux du Québec
Monsieur le président-directeur général Benoit Morin
Centre intégré de santé et de services sociaux de l'Ouest de l'Ile de Montréal

Objet : Maintien du niveau de soins et services aux anciens combattants de l'Hôpital Sainte-Anne

Membres du comité transitoire,

La présente est pour solliciter votre écoute et votre intervention urgente quant au maintien du niveau de soins et de services de santé pour les anciens combattants de l'Hôpital Sainte-Anne. Les engagements pris par l'ancienne administration de l'Hôpital Sainte-Anne envers les salariées, ainsi que l'information transmise à la nouvelle organisation syndicale PSSU-FIQ, sont à l'effet que CANADA, QUÉBEC et l'ÉTABLISSEMENT s'engagent à maintenir le niveau de soins et de services de santé sur les unités hébergeant des anciens combattants. Notre constat est à l'effet que cet engagement n'est pas respecté, et ce, depuis la date de cession du 1er avril 2016.

En effet, depuis le transfert, le manque constant de professionnelles en soins affecte directement la qualité des soins offerts aux anciens combattants. Malgré les efforts du nouvel employeur pour tenter de recruter du nouveau personnel, le personnel demeure insuffisant et nos professionnelles en soins se retrouvent fréquemment à travailler à personnel réduit et en fardeaux de tâche, ce qui affecte directement les soins aux anciens combattants. La difficulté récurrente de l'employeur à assurer la continuité des soins a des conséquences néfastes sur l'ensemble des résidents, leurs familles et les salariées. Nous constatons depuis le transfert plusieurs démissions du personnel soignant, plaintes des résidents et familles et détresse du personnel en place.

L'expertise gériatrique que l'Hôpital Sainte-Anne avait acquise avec labeur au cours des années est en péril. Nos résidents, avec une moyenne d'âge d'environ 92 ans, avec plusieurs problématiques de santé liées au vieillissement, représentent une clientèle vulnérable et fragile qui a besoin de soins professionnels et attentionnés. Dans les circonstances actuelles, il est impossible de continuer à offrir le même service de qualité auquel ils ont droit et qu'ils ont connu. Nous voyons quotidiennement des manques à plusieurs niveaux et une détérioration de l'état de santé des résidents dénoncés par le personnel soignant. Ces travailleuses portent l'hôpital à bout de bras et sont découragées de voir le chaos régner dans l'organisation des soins depuis le 1er avril.

La direction du CIUSSS connait l'état désastreux de la situation et continue de mettre en place des changements dans un échéancier serré et sans avoir d'abord stabilisé le transfert de juridiction du fédéral au provincial de

l'Hôpital Sainte-Anne. De nouvelles admissions admis à un rythme accéléré et dont la lourdeur et la mixité des cas a accentué la pression sur le personnel en place accentuent la pression. Les protocoles de standardisation de soins du CIUSSS ont commencé à être instaurés, ceux-ci étant bien différents de ce que les anciens combattants ont pu recevoir. De plus, le discours de l'employeur d'effectuer une "harmonisation" de ses méthodes à l'ensemble de l'hôpital nous porte à croire que les préoccupations budgétaires sont plus importantes que de conserver la réputation de haut niveau qu'avait acquise l'hôpital Sainte-Anne. Nous constatons déjà des difficultés d'effectuer une surveillance et d'offrir des soins sécuritaires et de qualité aux nouveaux patients admis. Aussi, l'arrivée la semaine dernière de 96 patients civils du centre de soins prolongés Grace Dart en provenance de l'est de l'île de Montréal suscite à nouveau des changements et une autre transition majeure dans l'organisation de l'Hôpital Sainte-Anne. Le manque de personnel lié au transfert de Grace Dart, jumelé à notre manque criant actuel, nous inquiète grandement. Les professionnelles en soins attitrées aux soins des anciens combattants sont sollicitées pour venir en aide pour l'accueil des patients de l'est, mais qui aide les salariées de l'Hôpital Sainte-Anne?

Nous sommes fatiguées. Voir la situation se détériorer de jour en jour nous force à demander de l'aide. Les gens qui travaillent ici ont à cœur leur profession et veulent continuer d'offrir des soins sécuritaires et de qualité à nos anciens combattants. La promesse qui a été faite n'est pas respectée. Et si l'Hôpital Sainte-Anne a déjà été un milieu de soins de référence, il est en train lentement de disparaître. Il est infiniment triste de constater tout le stress et l'impuissance auxquels sont confrontés nos anciens combattants et notre personnel soignant depuis le transfert.

Il est de la responsabilité de l'Établissement de s'assurer d'une organisation du travail saine et d'un environnement de travail sécuritaire pour ses salariées et de la qualité des soins pour les anciens combattants. L'entente de cession prévoit que votre comité a le mandat de s'assurer du respect du maintien du niveau de soins et des services de santé. Nous vous réitérons que l'organisation du travail y incluant le niveau de soins offerts dans les circonstances est très difficile depuis le transfert du fédéral au provincial. Nous demandons votre intervention rapide auprès des différentes instances appropriées afin que soit rétabli le niveau de soins qui était offert aux anciens combattants précédant le transfert, ainsi que pour le bien-être et la santé de l'ensemble des nouveaux bénéficiaires de l'Hôpital Sainte-Anne.

Dans l'attente d'un suivi de votre part, veuillez agréer nos sincères salutations,

Marie-André Legault
Infirmière et présidente locale

Dominique Nadeau
Infirmière et représentante locale

Patrick Lauzon
Inhalothérapeute et représentant syndical

Mohamed Lamine Charifi
Infirmier clinicien et représentant syndical

L'Exécutif syndical
Professionnelles en Soins de Santé Unies de l'Hôpital Sainte-Anne – PSSU affiliée à la
Fédération interprofessionnelle de la santé du Québec – FIQ
305, boul. Des Anciens-Combattants
Sainte-Anne-de-Bellevue (Québec) H9X 1Y9
Tel: 514-457-3440 # 2575

c.c. : M. Michel Léger, président PSSU
Mme Régine Laurent, présidente FIQ

No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

WOLF WILLIAM SOLKIN

Plaintiff

vs.
THE ATTORNEY GENERAL OF CANADA
-and-
THE ATTORNEY GENERAL OF QUEBEC
-and-
THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

LIST OF EXHIBITS AGC-1 TO AGC-25
IN SUPPORT OF THE DEFENCE
OF THE ATTORNEY GENERAL OF CANADA

EXHIBIT AGC-19

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O/Ref : 9683661 BC0565

Veterans Affairs Canada | Anciens Combattants Canada

Deputy Minister | Sous-ministre

AGC-20

OCT 03 2017

Michel Fontaine
Sous ministre
Santé et Services sociaux
1075, chemin Sainte-Foy, 14e étage
Québec (Québec) G1S 2M1

Monsieur Fontaine, Cher Michel,

Vous vous souviendrez de notre entretien téléphonique du 13 septembre 2017, lors duquel nous avons discuté de l'état de situation de la transition de l'Hôpital Sainte-Anne. Tel que convenu lors de notre entretien, vous trouverez dans la présente lettre un résumé des points que nous avons abordés, y compris des précisions concernant les défis à la Clinique pour traumatismes liés au stress opérationnel.

Tout d'abord, je vous ai fait part de mes préoccupations quant aux niveaux de dotation du personnel à l'Hôpital. La dotation, inférieure à ce que l'on avait prévue, persiste depuis plusieurs mois et a une incidence directe sur les services et les soins que reçoivent les vétérans. Nous avons en fait noté une présence minimale d'employés dans toutes les unités de l'Hôpital. De plus, plusieurs unités de vétérans sont dotées principalement d'employés contractuels ou temporaires entrainant des enjeux de continuité de soins.

Les enjeux liés à dotation du personnel ont été exacerbé pendant la saison estivale, et ce, malgré le plan d'action du Centre intégré universitaire de Santé et de Services sociaux de l'Ouest-de-l'Île-de-Montréal présenté le 9 juin 2017 à la rencontre du Comité de transition. Le plan d'action devait atténuer les perturbations liées au personnel.

On m'a également informé que le temps d'attente pour consulter un spécialiste est maintenant beaucoup plus long qu'il ne l'était avant le transfert de l'Hôpital. Le délai moyen d'attente varie présentement de trois à quatre mois, comparativement à un mois avant le transfert.

La Clinique pour traumatismes liés au stress opérationnel demeure aussi une source de préoccupation. Le 14 août 2017, le Lieutenant-général (à la retraite) et représentant des vétérans au Comité de transition, Michel Maisonneuve, a animé une réunion avec quelques vétérans pour recueillir leurs commentaires sur la qualité et la disponibilité des services et des activités thérapeutiques à la Clinique. Généralement, les commentaires dénotent qu'il existe une diminution dans la disponibilité des services.

.../2

Selon les vétérans, il y aurait moins de professionnels de la santé depuis le transfert, ce qui se traduit par une diminution des services et une liste d'attente plus longue pour les services de physiothérapie, de psychiatrie et de médecine générale à la Clinique. Le manque de professionnels en santé mentale mènerait aussi à une réduction des sessions et ateliers de groupe ainsi que des discussions dirigées. Les vétérans ont également soulevé que le bilinguisme n'est pas respecté et que les communications écrites sont manquantes entre la gestion administrative et les vétérans.

Il aurait existé avant le transfert une plus grande transparence de la part de la gestion administrative de la Clinique dans les communications et les informations transmises aux vétérans. Un exemple qui a constamment été utilisé par les vétérans est celui du cours de yoga, particulièrement l'annulation de ce service au sein de la programmation des cliniques et le changement de local. Selon les vétérans, il existe aussi un problème plus fondamental, soit le manque de connaissance de la part de la gestion administrative sur la culture, l'esprit et la réalité militaire.

Comme ce sont des points de discussion récurrents lors des réunions du Comité de transition, je propose que le Centre intégré universitaire de Santé et de Services sociaux de l'Ouest-de-l'Île-de-Montréal élabore et présente un plan d'action qui traitera spécifiquement de ces défis à la prochaine réunion du Comité de transition le 23 octobre 2017. Je propose aussi que nous travaillions en plus étroite collaboration afin de régler ces défis. Nous devrions nous rencontrer à nouveau en novembre en vue d'évaluer les modalités du plan et les progrès réalisés.

Je vous remercie de l'attention que vous porterez à ces défis.

Veuillez agréer, Monsieur Fontaine, l'expression de mes sentiments distingués.

Merci pour l'appui

W.J. Natynczyk
Général (à la retraite)
Sous-ministre

No. 500-06-000952-180

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WOLF WILLIAM SOLKIN

Plaintiff

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O/Ref : 9683661 BC0565

Veterans Affairs Canada — Anciens Combattants Canada
Deputy Minister — Sous-ministre

AGC-21

AUG 2 8 2018

Monsieur Michel Fontaine
Sous-ministre
Santé et Services sociaux
1075, Chemin Sainte-Foy, 14e étage
Québec (Québec) G1S 2M1

Objet : Soins et services aux vétérans à l'Hôpital Sainte-Anne

~~Monsieur~~, Cher Michel,

Cette lettre fait suite à une rencontre organisée par le nouveau président ainsi que le nouveau vice-président du Comité des vétérans de l'Hôpital Ste-Anne à laquelle j'ai été convié mardi le 17 juillet 2018 à l'Hôpital Sainte-Anne. Une quinzaine de personnes se sont jointes à cette rencontre, notamment des vétérans, des membres des familles, des employées ainsi que des bénévoles, pour témoigner de leur expérience à l'Hôpital. L'agente de liaison d'Anciens Combattants Canada (ACC) ainsi que Mme Maryse Savoie, représentante d'ACC sur le Comité de transition, étaient également sur place.

Lors de cette rencontre, les personnes présentes ont exprimé, parfois avec beaucoup d'émotions, leur insatisfaction et leurs craintes quant aux soins et aux services dispensés aux vétérans de l'Hôpital. Il apparaît clair, quant à eux, que l'engagement quant au maintien du niveau de soins et du bilinguisme n'est pas respecté de manière satisfaisante. Plusieurs des situations évoquées ont démontré l'insuffisance de personnel de soins tant en quantité qu'en qualité et la méconnaissance générale de la culture des vétérans. Le recours aux agences est fréquent et le personnel change constamment, ce qui affecte la stabilité des équipes et la continuité des soins. À titre d'exemple, la fin de semaine du 14 et 15 juillet dernier au 11e étage, il n'y avait apparemment qu'une seule infirmière de jour pour 33 résidents. Les familles ont relaté plusieurs erreurs de médication, une augmentation des chutes, un manque au niveau des soins d'hygiène et d'alimentation ainsi que l'apparition de plaies de pression chez leurs parents hébergés. Plusieurs affirment devoir exercer une surveillance constante des soins prodigués, et surtout pour les vétérans ne pouvant s'exprimer par cause de défis cognitifs. En outre, la difficulté d'assurer le bilinguisme rend difficile la communication et la compréhension de certaines consignes, compromettant ainsi la sécurité de leurs proches.

.../2

Certes, nous avons remarqué au cours des derniers mois, certaines améliorations en matière de ressources humaines à l'Hôpital telles que de nouvelles embauches, la création de postes à temps complet et la mise sur pied d'une école de préposés aux bénéficiaires. Nous pouvons également constater une volonté de la part de vos équipes à vouloir mieux faire ainsi qu'une ouverture accrue à travailler en partenariat. À cet égard, un comité de travail paritaire CIUSSS/ACC à récemment été mis sur pied. Ce comité ne s'est pas encore rencontré, mais possède le potentiel d'assurer un meilleur suivi de la situation. Dans ce même esprit, une rencontre a eu lieu jeudi le 19 juillet 2018 avec le directeur général des ressources humaines du CIUSSS et la directrice de l'établissement afin d'échanger et d'explorer de nouvelles pistes d'améliorations. À l'issue de cette rencontre, il a été convenu de mener de façon conjointe une évaluation portant sur trois volets:

1) Un sondage de satisfaction auprès des vétérans / familles concernant les soins prodigués;
2) Un portrait des ratios du personnel sur les trois quarts de travail, sur les unités de soins des vétérans pour une période minimale de trois mois;
3) Une cueillette de données et l'analyse des besoins individuels de chacun des vétérans hébergés à l'Hôpital Sainte-Anne.

Nous croyons que cette évaluation fournira un aperçu objectif de la situation à l'Hôpital Sainte-Anne et évitera de tirer des conclusions hâtives ou de généraliser les incidents et leur nature.

Bien que ce projet d'évaluation soit un pas dans la bonne direction, je demeure néanmoins préoccupé par le maintien du niveau de soin et de bilinguisme à l'Hôpital et de l'urgence de prendre action étant donné l'âge moyen de nos vétérans (95 ans). Dans les prochaines semaines, mon bureau organisera un rendez-vous téléphonique avec vous afin de pouvoir pousser plus loin la discussion.

En terminant, je tiens à réitérer l'ouverture d'ACC à toutes formes de collaboration. Nous sommes prêts à contribuer aux ressources nécessaires pour assurer le respect de notre engagement auprès de nos vétérans qui, nonobstant leur hébergement à l'Hôpital, demeurent nos clients et notre responsabilité aux termes de la *Loi sur le ministère des Anciens Combattants*. Soyez assuré, Monsieur le sous-ministre, de ma collaboration.

Je profite de l'occasion pour vous souhaiter une très bonne fin de saison estivale.

Cordialement,

W. J. Natynczyk
Général (à la retraite)
Sous-ministre

No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

WOLF WILLIAM SOLKIN

Plaintiff

vs.

THE ATTORNEY GENERAL OF CANADA

-and-

THE ATTORNEY GENERAL OF QUEBEC

-and-

THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

LIST OF EXHIBITS AGC-1 TO AGC-25
IN SUPPORT OF THE DEFENCE
OF THE ATTORNEY GENERAL OF CANADA

EXHIBIT AGC-21

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Representation of Veterans at Ste. Anne's Hospital

CONTEXT

The Sainte-Anne Hospital Transfer Agreement (the Agreement) provides for the creation of a Transition Committee (Committee). The Committee is made up of two representatives from the Quebec Ministry of Health and Social Services, two representatives from the Department of Veterans Affairs Canada, one Veterans representative and two representatives from the Integrated University Health and Social Services Centres (CIUSSS) of the West Island of Montreal and a representative of the CIUSSS Board of Directors for the West Island of Montreal.

The Committee has, among others, the following mandates:

- Ensure the implementation of the provisions, conditions and obligations of the Agreement;
- Ensure that the level of care and services for veterans is maintained as stipulated in the Agreement;
- Establish a formal forum for discussion of any matter the Committee deems relevant to the implementation of the provisions, conditions and obligations of the Agreement and the smooth transition of Ste. Anne's Hospital to the Quebec health and social services network.

At the February 8, 2017 meeting, committee members supported the creation of veterans' representation at Ste. Anne's Hospital to further the transition. It was proposed that this representation be comprised of a Veteran representative and a Veterans Affairs Canada Liaison Officer.

The objectives of this Office are listed below:

- Facilitating the transition;
- Contribute to the promotion and recognition of the role of the representative of the Complaints and Service Quality Commission of the CIUSSS West Island (complaint representative);
- Allow Veterans and their families to share and discuss concerns;
- Ensure a transfer of concerns to the representative of the Commissioner of Complaints.

The Liaison Officer Reports to the Veteran representative.

Veterans Affairs Liaison Officer recruitment

The liaison officer proposed by Veterans Affairs Canada is selected with the concurrence of the Veteran representative, the Director of the Seniors' Independence Program and the Complaints Representative.

Role and Mandate - VAC Liaison Officer at Ste. Anne's Hospital

Role description:

In addition to reiterating the commitment of Veterans Affairs Canada (VAC) to veterans at Ste. Anne's Hospital, the Day Center, and the Residential Clinic, the liaison officer, in close

collaboration with the Veteran representative and the representative of the Complaints Commission, will be responsible for informing, reassuring and facilitating communications between Veterans, their families and the new Ste. Anne's Hospital organization, to assist and support them in the transition.

Mandates/Responsabilities:

- Develop and maintain a collaborative relationship with the representatives of Ste. Anne's Hospital, the Director of the Seniors' Independence Program and the Director of Mental Health and Addiction Programs CIUSSS-WIOM by addressing first the representative of the complaints commission via statutory meetings;
- At the invitation of the Co-Chairs, attend the Transition Committee meetings;
- Ensure visibility (a caring presence) at Ste. Anne's Hospital;
- With the participation of the Veteran representative, create opportunities as needed to get in touch with veterans and their loved ones (coffee meeting, information sessions, etc.) and allow them to share and discuss their concerns;
- At the invitation of the President (Mr. Stuart Vary), participate, along with the representative of the Complaints Commissioner, in meetings of the Residents Committee of Ste. Anne's Hospital;
- Provide information to Veterans, their families and their representatives to help promote and recognize the role of the representative of the Complaints and Service Quality Commission of the CIUSSS-WIOM (Complaints Representative);
- Ease the transition;
- Facilitate communications between Veterans, their families, their representatives and Ste. Anne's Hospital and the CIUSSS-WIOM, in some cases acting as an intermediary;
- Ensure a transfer of concerns and refer, as needed, Veterans and their relatives to the nurse, and / or Unit Head and / or the representative of the Complaints Commission;
- Ensure regular accountability to the Transition Committee.

Profile/qualities sought:

- Great interpersonal skills;
- Ease of communication with Veterans and their loved ones and ability to listen and empathize;
- Communication and collaboration skills;
- Ability to establish and maintain harmonious relationships, tact and diplomacy;
- Ability to solve complex situations;
- Possess analytical capacity and good judgment / maturity;
- Ability to communicate verbally and in writing in French and English;
- Knowledge of the long-term care environment;
- Sense of ethics;
- Autonomy.

STOWAGE

In the event of a conflict between the liaison officer and the representative of the complaints commissioner, the liaison officer shall refer to the Veteran representative and the complaints representative to his immediate superior. However, the liaison officer must inform the

director general of field operations and the complaints representative must inform the director of the program to support the independence of the elderly.

The transition committee may be called upon to intervene to settle a dispute.

The Veterans Affairs Representative, the Director General of Field Operations, the Director of Mental Health and Addiction and the Director of the Seniors' Independence Program collaborate to promote quality service to Veterans.

OTHER TERMS

- Make two offices available on the third floor of the main lodge;
- Provide two access cards;
- Provide two phones;
- Provide a printer without network access (RTSS);

DURATION OF THE VAC LIAISON AGENT MANDATE

The mandate term of the Veterans Affairs Canada Liaison Officer extends over a 6-month period beginning April 10, 2017. The Liaison Officer will be on duty 5 days a week for the first 4 weeks and 3 days a week thereafter.

April 3, 2017

No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

WOLF WILLIAM SOLKIN

Plaintiff

vs.
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-and-
THE ATTORNEY GENERAL OF QUEBEC
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Defendants

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EXHIBIT AGC-22

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O/Ref : 9683661 BC0565

AGC-23

Centre intégré
universitaire de santé
et de services sociaux
de l'Ouest-de-
l'Île-de-Montréal
Québec

Rapport

Sondage sur l'expérience client

Hôpital Sainte-Anne

Présenté par : Service de la qualité
pour la Direction du programme de soutien à l'autonomie des personnes âgées

Date : Janvier 2017

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INTRODUCTION

Le CIUSSS de l'Ouest-de-l'île-de-Montréal est d'avis que l'évaluation de l'expérience vécue par les usagers soit non seulement une mesure de performance, mais la voie d'expression de ces derniers, ainsi que de leurs proches. Sonder l'opinion des usagers permet d'avoir leur perception sur la qualité des services offerts afin d'implanter des améliorations adéquates, de considérer les pratiques organisationnelles et professionnelles en fonction de leurs attentes, en plus de souligner les bons coups des équipes cliniques.

Pour la clientèle en hébergement de la Direction du programme de soutien à l'autonomie des personnes âgées (SAPA), l'expérience des usagers peut se mesurer en demandant aux résidents d'évaluer leur qualité de vie et la qualité des services reçus selon leur expérience personnelle. La qualité de vie est reconnue comme un résultat important au plan de la santé dans les milieux de soins de longue durée (Kehyayan et al., 2015).

De plus, ce processus d'évaluation contribue à répondre aux directives en matière de qualité du milieu de vie du Ministère de la Santé et des Services sociaux ainsi qu'aux exigences d'Agrément Canada.

Finalement, la cession officielle de l'Hôpital Sainte-Anne du ministère des Anciens Combattants au réseau de la santé et des services sociaux du Québec a pris effet le 1er avril 2016. À cet effet, ce centre d'hébergement a été cédé au CIUSSS de l'Ouest-de-l'Île-de-Montréal. Pour assurer le maintien de la qualité des services à la suite de ce changement, le site de l'Hôpital Sainte-Anne a donc été priorisé comme point de départ pour l'évaluation de l'expérience vécue par les usagers de la direction du programme SAPA.

OBJECTIFS

À court terme :

- Sonder les résidents de l'Hôpital Sainte-Anne au sujet de leur expérience et de leur qualité de vie.
- Fournir des renseignements sur la qualité de vie à l'Hôpital Sainte-Anne du point de vue des résidents pour contribuer à l'amélioration locale, dans un contexte de changement.

À moyen-long terme :

- Fournir des renseignements sur l'expérience des résidents de l'Hôpital Sainte-Anne pour contribuer à l'amélioration continue de la qualité.
- Pouvoir se comparer dans le temps et entres installations de la direction du programme SAPA.
- Pouvoir identifier et améliorer des problèmes systémiques en soins de longue durée.

SECTION 1 : RÉSIDENTS DU PAVILLON PRINCIPAL

Méthodologie

Questionnaire

À la suite d'une analyse comparative, le questionnaire du *sondage autoadministré interRAI© sur la qualité de vie en établissement de soins de longue durée (maisons de soins infirmiers)* a été sélectionné. interRAI est un consortium international de recherche sans but lucratif qui développe des instruments d'évaluation validés et qui promeut la pratique clinique et la prise de décision éclairée par les données. Les propriétés psychométriques de cet instrument, utilisé par plusieurs établissements à travers le pays, ont été testées au Canada et ont soutenu sa fiabilité et la validité de sa convergence et de son contenu pour l'évaluation de la qualité de vie des résidents (Kehyayan et al., 2015).

Pour utiliser ce questionnaire, une licence d'impression a été acquise. La version en français, dont l'évaluation des propriétés psychométrique est en cours, a été mise à notre disposition par l'équipe du Dr. Hirdes de l'Université de Waterloo. Le guide d'utilisateur du sondage élaboré par interRAI a été utilisé pour guider la méthodologie d'administration du questionnaire. De plus, un pré-test auprès de six résidents a aussi servi à orienter la démarche.

Le questionnaire mesure principalement des aspects reliés à la qualité de vie des résidents selon les thèmes suivants :

- Respect (4 items)
- Confidentialité (2 items)
- Sécurité (3 items)
- Confort (5 items)
- Autonomie (7 items)
- Soutien du personnel (7 items)
- Relations avec le personnel (6 items)
- Relations personnelles (5 items)
- Activités (6 items)
- Nourriture et repas (5 items)

Il comprend 50 questions à choix de réponse, cinq questions sociodémographiques et une question ouverte. Quelques modifications ont été faites au questionnaire pour adapter certain termes techniques au vocabulaire employé par le personnel et les résidents de l'Hôpital Sainte-Anne et pour ajuster les catégories d'âge dans les questions sociodémographiques. De plus, la question ouverte a été remplacée par deux questions ouvertes portant sur ce que les résidents aiment le plus et sur ce qui pourrait être amélioré. Les questions à choix de réponse sont présentées sous forme d'énoncé avec une échelle de mesure de la fréquence des expériences vécues (jamais, rarement, parfois, la plupart du temps, toujours). Trois réponses supplémentaires peuvent être codées au besoin, soit 'ne sais pas', 'refuse' ou 'aucune réponse ou ne peut être déterminé d'après ce qui a été répondu'.

Caractéristiques des participants

Résidents inclus dans le sondage

- Anciens combattants du pavillon principal

Résidents exclus du sondage

- Anciens combattants du pavillon du Souvenir (autre méthode de sondage – voir section 2)
- Résidents civils
- Résidents avec niveau de capacité cognitive trop faible – ne pouvant pas répondre selon les choix de réponses à trois questions consécutives
- Refus de participation (raisons : état de santé ou autre)

Échantillonnage

Pour une population totale de 171 résidents en date du 24 octobre 2016, un échantillon minimal de 62 a été calculé pour un niveau de confiance de 95% et un intervalle de confiance de 10. Pour favoriser la représentativité de l'échantillon, un échantillonnage stratifié selon les unités de soins a été utilisé. Une division selon la langue parlée (anglais ou français) a aussi tenté d'être respectée (voir tableau1). Par la suite, un échantillon de convenance a été choisi sur chaque unité : une période d'un à deux jours a été accordée pour sonder chaque unité et les résidents présents et disponibles à ce moment-là ont été invités à participer.

Tableau 1: Échantillon stratifié par unité de soins

Unité de soins	Nombre de lits	Total de résidents En date du 24 octobre 2016	Nombre de résidents parlant le...			Nombre de sondages à effectuer			
			Français (FR)	Anglais (ANG)	Bilingues (FR & ANG)	Total	FR	ANG	FR ou ANG
T04	33	33	9	16	8	11	3	5	3
T05	33	29	7	14	8	11	3	5	3
T09	33	27	9	12	6	10	3	4	2
T11	33	29	6	14	9	11	2	5	3
T12	33	31	10	13	8	11	4	5	3
T14	33	22	8	11	3	9	3	4	2
SOMME:	198	171	49	80	42	62	18	28	16

L'administration des sondages a eu lieu du 17 octobre au 22 novembre 2016. Au total, 99 résidents ont été approchés pour participer et 72 ont complété le sondage. Ceci représente 42% des résidents du pavillon principal.

Tableau 2: Distribution des répondants par unité et par langue

	Complété ANG	Complété FR	**Complété Total**	Refus	Ne peux pas	TOTAL
T04	5	4	9	0	1	10
T05	6	2	8	1	5	14
T09	10	8	18	0	2	20
T11	5	5	10	0	0	10
T12	7	6	13	4	7	24
T14	8	6	14	4	4	22
Total	40	31	72	9	19	99

Collecte de données

Comme l'indique le guide d'utilisateur d'interRAI, bien que l'information recueillie auprès des proches et des familles soit d'une grande valeur pour l'amélioration de la qualité, elle ne peut être considérée comme un substitut aux réponses recueillies directement auprès des usagers. Le mode d'administration préconisé est donc l'entrevue personnelle structurée pour permettre aux résidents avec différents niveaux de capacité cognitive de répondre eux-mêmes au questionnaire.

Entrevues et enregistrement des réponses

Les entrevues structurées d'une durée d'environ 60 min ont été faites par une infirmière de la clinique des bénéficiaires de l'Hôpital Sainte-Anne et par les membres du l'équipe du service de la qualité du CIUSSS. Le recours aux bénévoles ou aux étudiants en soins infirmiers n'a pas été possible en raison des courts délais et du besoin de formation de ceux-ci. Les intervieweurs ont appliqué les directives établies pour le *BC Office of the Seniors Advocat's 2016/17 Residential Care survey* pour réaliser une entrevue structurée tel que stipulé dans leur vidéo de formation à ce sujet (disponible ici : http://surveybcseniors.org/resources/). Pour maintenir la confidentialité, les entrevues ont eu lieu le plus possible dans la chambre des résidents, tout en respectant leurs préférences.

Les énoncées du questionnaire doivent être lu exactement tel qu'écrit et peuvent être répété jusqu'à trois fois au besoin. De plus, le *Patient-Centred Performance Measurement & Improvement* du ministère de la santé de la Colombie-Britannique nous a accordé l'autorisation d'utiliser leur cartes aide-mémoire et leurs questions alternatives standardisées (*standardized probes)* développées pour le *BC Office of the Seniors Advocat's 2016/17 Residential Care survey*. La carte aide-mémoire pouvait être utilisée pour faciliter la sélection d'un choix de réponse pendant l'entrevue, selon le besoin. Les questions alternatives standardisées ont été utilisées seulement lorsqu'une question n'était pas bien comprise, et ce, seulement après trois répétitions de la question du sondage.

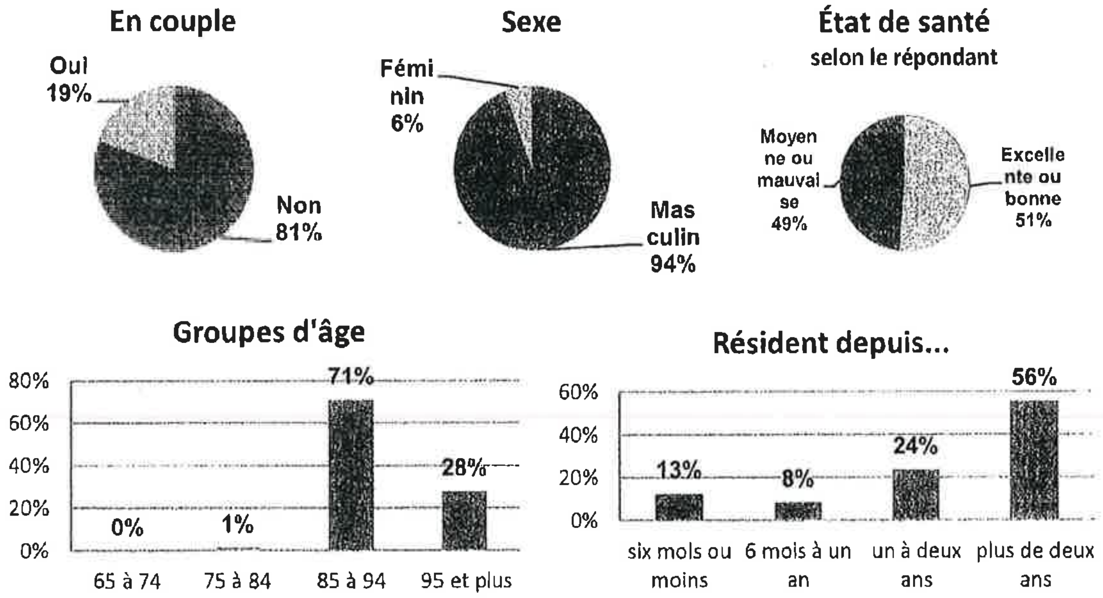
Analyse des données

La collecte des questionnaires et la saisie des données dans un fichier Excel ont été réalisées par l'équipe du service de la qualité. La distribution des données démographiques a été calculée. L'homogénéité des répondants n'a pas permis d'analyse par sous-groupe selon les données démographiques. Pour les questions à choix multiples, les fréquences, pourcentages, moyennes et écart types des résultats ont été examinés. Pour permettre l'analyse des moyennes obtenues par thématique, les réponses 'ne sais pas', 'refuse' ou 'aucune réponse ou ne peut être déterminé d'après ce qui a été répondu ont été recodées comme 'parfois', soit le point neutre, selon la méthode d'analyse de Kehyayan, Hirdes, Tyas et Stolee (2015). Puisque chaque thème est composé d'un nombre différent d'items, des scores moyens standardisés ont aussi été calculés avec un score maximal de 4. Une analyse thématique du contenu des questions ouvertes et des autres commentaires a aussi été faite.

Résultats

Données démographiques des répondants

Parmi les 72 répondants, presque tous ont 85 ans ou plus (99%, n=71) et sont de sexe masculin (94%, n=68). La majorité des répondants résident à l'Hôpital Saint-Anne depuis plus d'un an (80%, n=57) en date du mois d'octobre 2016.



Résultats : questions ouvertes et autres commentaires

L'analyse thématique des réponses obtenues aux questions ouvertes et des commentaires exprimés par les répondants au courant du sondage a permis d'identifier plusieurs points positifs et points d'améliorations liés à la qualité de vie des résidents.

Qu'est-ce que vous aimez le plus à l'Hôpital Sainte-Anne?

Quatre thèmes identifiés (nombre de commentaires recueillis à ce sujet):

- Qualité et variété des soins et services (traitements/interventions, services récréatifs, etc.) (20)
- Équipe de soins (compétences, relation, collaboration, etc.) (16)
- Environnement (physique, social, qualité des repas, propreté, sécurité, etc.) (35)
- Offre de service en général (8)

Qu'est-ce qui pourrait être amélioré à l'Hôpital Sainte-Anne?

Trois thèmes identifiés (nombre de commentaires recueillis à ce sujet):

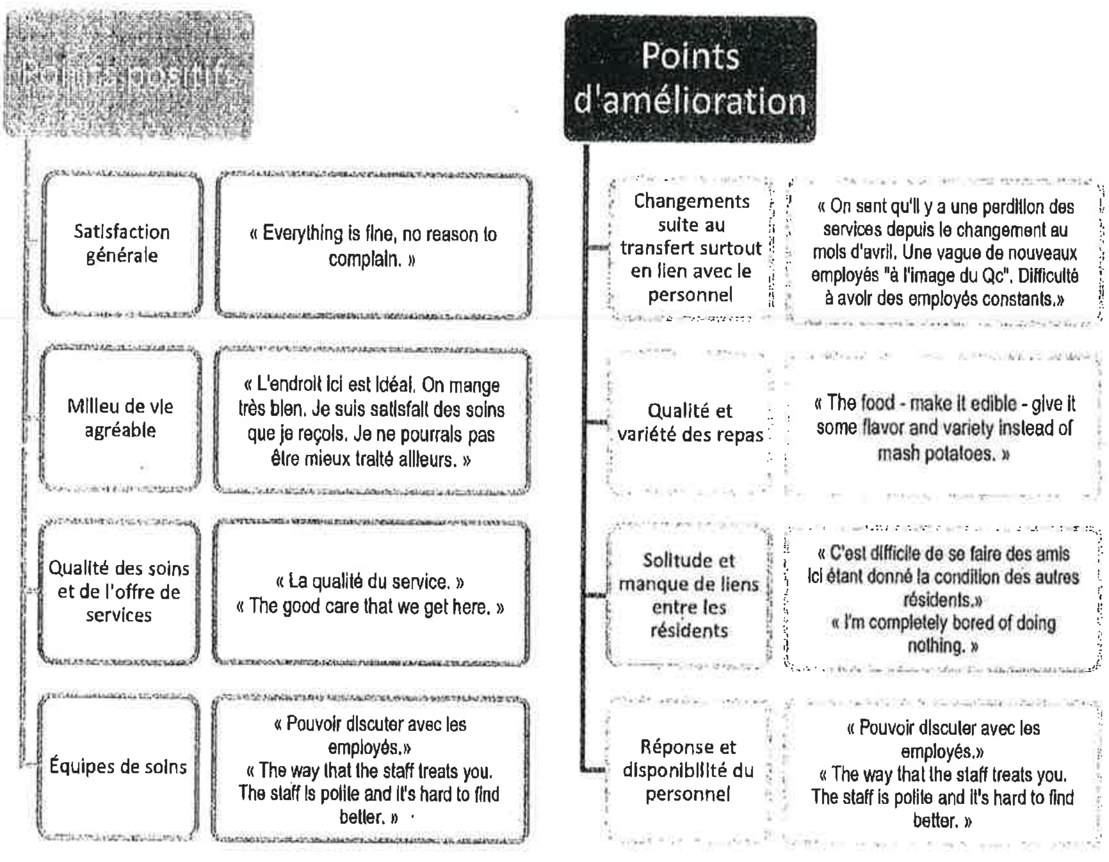
- Aucune recommandation/globalement satisfait (20)
- Réorganisation des services depuis le transfert fédéral - provincial (roulement du personnel, instabilité, sentiment d'appartenance, ressources, formation, professionnalisme, etc.) (20)
- Repas, services et environnement (choix et qualité des repas, services, environnement, etc.) (25)

Autres commentaires

Quatre thèmes identifiés (nombre de commentaires recueillis à ce sujet):

- Environnement et milieu de vie agréables, respectueux et sécuritaires (17)
- Soins et services de qualité (7)
- Changements importants suite au transfert fédéral - provincial (roulement personnel, services, ressources, etc.) (11)
- Isolement/solitude (4)

Figure 1 : Points principaux et citations tirés des questions ouvertes et des commentaires



Résultats : questions à choix multiples

Scores par thème (tableau 3) **:**

- La sécurité, le respect par le personnel et la vie privée des résidents sont les thèmes qui globalement ont reçus les scores les plus élevés. Ces résultats se reflètent également dans les commentaires spécifiques à ces sections qui ont été recueillis lors des entrevues. Cependant, les résidents ont parfois nuancé la réponse choisie par rapport au nouveau personnel et aux changements depuis le transfert.
- Le lien entre les résidents et les membres du personnel, les activités et les relations interpersonnelles sont les thèmes qui globalement ont reçus les scores les plus faibles. Les commentaires recueillis tout au long des sondages nous permettent de comprendre que les résidents ne bâtissent pas beaucoup de liens entres eux. Ceci donne d'autant plus d'importance aux liens tissés avec le personnel pour pouvoir répondre au « besoin d'appartenance », un besoin de haut niveau dans la pyramide de Maslow. Le faible score des activités reflète l'opinion très partagée des résidents à ce sujet, visible dans le tableau 4, et des scores qui s'apparentent parfois plus aux préférences des gens qu'à la disponibilité des activités.
- À noter que le thème de la nourriture et des repas, ayant reçu un score global de 12.6/20, a reçu plusieurs commentaires positifs sur l'appréciation de l'heure du repas. Par contre, plusieurs commentaires négatifs ont aussi été reçus au sujet du non-respect des horaires, de la cuisson des aliments et de la viande inadéquate, ainsi que de la qualité et la variété des repas ayant diminuées depuis le transfert.

Tableau 3: Scores moyens et standardisés par thème – pavillon principal

Thème (nombre d'items)	Moyenne	Écart type	Moyenne (intervalle de confiance de 95%)	Scores possibles	Scores moyens standardisés (sur 4.0)	Canada* (sur 4.0)
Sécurité (3)	9.46	1.98	9.5 (9.0 to 9.9)	0-12	3.2	3.2
Respect par le personnel(4)	12.47	2.75	12.5 (11.8 to 13.1)	0-16	3.1	2.9
Vie privée (2)	5.99	1.20	6.0 (5.7 to 6.3)	0-8	3.0	3.2
Réponse du personnel (4)	11.65	2.34	11.7 (11.1 to 12.2)	0-16	2.9	2.9
Autonomie (7)	19.85	5.14	19.9 (18.6 to 21.1)	0-28	2.8	2.7
Confort (5)	12.88	2.94	12.9 (12.2 to 13.6)	0-20	2.6	2.5
Nourriture et repas (5)	12.58	3.76	12.6 (11.7 to 13.5)	0-20	2.5	2.6
Lien résident-membres du personnel (5)	11.17	3.75	11.2 (10.3 to 12.1)	0-20	2.2	2.6
Activités (6)	12.99	4.45	13.0 (12.0 to 14.0)	0-24	2.2	2.7
Relations interpersonnelles (5)	8.67	4.01	8.7 (7.7 to 9.6)	0-20	1.7	2.0

*Source : Kehyayan et al., 2015

Tableau 4: Perspective des résidents sur leur qualité de vie par thème et item – pavillon principal

Thème	Items	*Toujours/La plupart du temps*	*Parfois*	*Rarement/ Jamais*	*Aucune réponse*
Vie Privée	Peux être seul	61.1% (44)	30.6% (22)	8.3% (6)	0% (0)
	Intimité respectée par le personnel	83.3% (60)	9.7% (7)	1.4% (1)	5.6% (4)
Nourriture et repas	Aliments préférés	41.7% (30)	33.3% (24)	18.1% (13)	6.9% (5)
	Manger quand voulu	36.1% (26)	23.6% (17)	29.2% (21)	11.1% (8)
	Repas variés	48.6% (35)	27.8% (20)	13.9% (10)	9.7% (7)
	Apprécie l'heure du repas	65.3% (47)	23.6% (17)	6.9% (5)	4.2% (3)
	Température des aliments	65.3% (47)	25% (18)	6.9% (5)	2.8% (2)
Sécurité	Obtenir l'aide requis	70.8% (51)	19.4% (14)	0% (0)	9.7% (7)
	Sécurité des effets personnels	81.9% (59)	8.3% (6)	6.9% (5)	2.8% (2)
	Se sentir en sécurité	87.5% (63)	5.6% (4)	4.2% (3)	2.8% (2)
Confort	Recevoir services requis	90.3% (65)	8.3% (6)	0% (0)	1.4% (1)
	Recommande l'hôpital	75% (54)	8.3% (6)	11.1% (8)	5.6% (4)
	Se sentir chez soi	65.3% (47)	13.9% (10)	18.1% (13)	2.8% (2)
	Facilité d'aller à l'extérieur	70.8% (51)	6.9% (5)	12.5% (9)	9.7% (7)
	Bruit incommodant	13.9% (10)	18.1% (13)	66.7% (48)	1.4% (1)
Autonomie	Peux prendre un bain ou une douche	41.7% (30)	13.9% (10)	33.3% (24)	11.1% (8)
	Décision de se lever	63.9% (46)	12.5% (9)	18.1% (13)	5.6% (4)
	Décision de se coucher	77.8% (56)	4.2% (3)	13.9% (10)	4.2% (3)
	Libre d'aller et venir	70.8% (51)	9.7% (7)	12.5% (9)	6.9% (5)
	Contrôle accès à la chambre	63.9% (46)	13.9% (10)	16.7% (12)	5.6% (4)
	Choix vestimentaire	77.8% (56)	5.6% (4)	12.5% (9)	4.2% (3)
	Décision occupations	83.3% (60)	9.7% (7)	4.2% (3)	2.8% (2)
Respect par le personnel	Traité avec respect	91.7% (66)	2.8% (2)	5.6% (4)	0% (0)
	Attention du personnel	81.9% (59)	9.7% (7)	4.2% (3)	4.2% (3)
	Exprimer son opinion librement	65.3% (47)	6.9% (5)	11.1% (8)	16.7% (12)
	Respect des préférences	72.2% (52)	8.3% (6)	4.2% (3)	15.3% (11)
Réponse du personnel	Vivre comme je le veux	66.7% (48)	13.9% (10)	6.9% (5)	12.5% (9)
	Rapidité de la réponse du personnel	84.7% (61)	9.7% (7)	1.4% (1)	4.2% (3)
	Donner suite aux suggestions	29.2% (21)	22.2% (16)	9.7% (7)	38.9% (28)
	Recevoir soins requis	86.1% (62)	5.6% (4)	5.6% (4)	2.8% (2)
Lien résidents-membres du personnel	Personnel connait mon histoire de vie	29.2% (21)	22.2% (16)	33.3% (24)	15.3% (11)
	Membre du personnel est un ami	68.1% (49)	18.1% (13)	6.9% (5)	6.9% (5)
	Lien particulier avec un membre du personnel	34.7% (25)	19.4% (14)	38.9% (28)	6.9% (5)
	Conversations amicales avec le personnel	51.4% (37)	26.4% (19)	16.7% (12)	5.6% (4)
	Personnel m'interroge sur mes besoins	37.5% (27)	18.1% (13)	26.4% (19)	18.1% (13)
Activités	Activités plaisantes les fins de semaine	38.9% (28)	29.2% (21)	25% (18)	6.9% (5)
	Activités plaisantes les soirs	36.1% (26)	26.4% (19)	27.8% (20)	9.7% (7)
	Activités enrichissantes	31.9% (23)	31.9% (23)	26.4% (19)	9.7% (7)
	Activités religieuses disponibles	44.4% (32)	20.8% (15)	18.1% (13)	16.7% (12)
	Occasions être avec d'autres qui partagent vision des choses	44.4% (32)	22.2% (16)	26.4% (19)	6.9% (5)
	Développer nouvelles habiletés et nouveaux intérêts	33.3% (24)	20.8% (15)	30.6% (22)	15.3% (11)
Relations interpersonnelles	Un autre résident est un ami proche	38.9% (28)	15.3% (11)	37.5% (27)	8.3% (6)
	Les gens me demandent aide ou avis	13.9% (10)	30.6% (22)	50% (36)	5.6% (4)
	Occasion de nourrir liens affectifs	9.7% (7)	16.7% (12)	59.7% (43)	13.9% (10)
	Facile de se faire des amis	48.6% (35)	25% (18)	19.4% (14)	6.9% (5)
	Des gens avec qui faire des activités	26.4% (19)	25% (18)	41.7% (30)	6.9% (5)

Résultats par item (tableau 4) :

- Toujours/La plupart du temps : 5 plus fréquents
    1. Traité avec respect – 91.7%
    2. Recevoir services requis – 90.3%
    3. Se sentir en sécurité – 87.5%
    4. Recevoir soins requis – 86.1%
    5. Rapidité de la réponse du personnel – 84.7%

- Rarement/Jamais : 5 plus fréquents
    1. Occasion de nourrir liens affectifs – 59.7%
    2. Les gens me demandent aide ou avis – 50.0%
    3. Des gens avec qui faire des activités – 41.7%
    4. Lien particulier avec un membre du personnel – 38.9%
    5. Membre du personnel est un ami – 37.5%
    - Personnel connait mon histoire de vie – 33.3% (et seulement 29.2% toujours/la plupart du temps)

- Plus de 15% sans réponse
    - Donner suite aux suggestions – 38.9%
    - Personnel m'interroge sur mes besoins – 18.1%
    - Activités religieuses disponibles – 16.7%
    - Exprimer son opinion librement – 16.7%

L'analyse des résultats par item démontre aussi que les soins et services, donnés avec respect par le personnel, sont les points forts selon les résidents. De plus, tous les items avec les résultats les plus faibles sont liés au concept de bâtir des liens interpersonnels. Il est intéressant de noter que certains items ont un pourcentage assez élevé sans réponse (refus, ne sais pas, aucune réponse obtenue). Des explications possibles à considérer sont l'intérêt des résidents envers l'item (ex : plusieurs ont exprimé ne pas être religieux) et la pertinence perçu de l'item (ex : ce n'est pas nécessaire).

Considérations éthiques

- **Approbation éthique :** le sondage s'est fait dans un contexte d'amélioration continue de la qualité, donc l'approbation du comité d'éthique de la recherche n'était pas nécessaire. Par contre, certaines considérations éthiques sont tout de même prises en compte dans l'administration du questionnaire.

- **Confidentialité** : les entrevues ont eu lieu dans des endroits privés, déterminés selon la préférence du répondant, sans la présence de personnel impliqués dans leurs soins ou services quotidiens. Les sondages complétés n'inclus aucun identifiant personnel et sont conservés dans un bureau du service de la qualité au Centre Hospitalier St-Mary. Bien que certaines informations telles que le nom et le numéro de chambre des résidents invités à participer ont été recueillis lors de la période d'administration du sondage à des fins de logistique et d'échantillonnage, ces informations ont été conservées séparément des questionnaires complétés et détruites par la suite.

- **Participation volontaire** : la participation au sondage était volontaire. Les résidents ayant participé au sondage pouvaient aussi s'abstenir de répondre à toute question sans invalider le reste de leurs réponses. Les intervieweurs n'étaient pas des membres de leur équipe de soins directe pour ne pas créer de biais et pour empêcher toute apparence de répercussions liées aux réponses données. Une attention particulière a été portée au confort des résidents lors des entrevues et à une participation libre et éclairée.

SECTION 2 : RÉSIDENTS DU PAVILLON DU SOUVENIR

Méthodologie

Questionnaire

Pour les résidents du pavillon du Souvenir, il n'était pas possible de procéder par entrevue auprès de ceux-ci dû à leurs capacités cognitives plus limitées et pour des questions d'aptitude au consentement. Une version légèrement modifiée du *sondage autoadministré interRAI© sur la qualité de vie en établissement de soins de longue durée (maisons de soins infirmiers)* au niveau de la présentation et des directives incluses a donc été envoyée par la poste à leurs proches en leur demandant de répondre selon le point de vue des résidents. Des enveloppes de retour préadressées et préaffranchies ont été fournies.

Caractéristiques des participants et Collecte de données

Résidents inclus dans le sondage

- Anciens combattants du pavillon du Souvenir via leur famille ou leur proche (le contact principal inscrit au dossier)

Résidents exclus du sondage

- Résidents civils
- Refus de participation

Échantillonnage

Pour une population totale de 104 résidents en date du 9 novembre 2016, un échantillon visé de 50 répondants a été calculé pour un niveau de confiance de 95% et un intervalle de confiance de 10.

Unité de soins	Nombre de lits	Total de résidents	Nombre de proches parlant le ...		Nombre de répondants visé		
		En date du 9 novembre 2016	Français (FR)	Anglais (ANG)	Total	FR	ANG
S2A	29	27	17	10			
S2B	29	26	16	10			
S3A	29	27	13	14			
S3B	29	24	12	12			
SOMME	116	104	58	46	50	28	22

L'envoi des sondages a eu lieu le 18 novembre 2016. Au total, 102[1] sondages ont été envoyés par la poste et 37 sondages complétés ont été reçus en novembre et décembre 2016. Ceci représente 36% des résidents du pavillon du Souvenir et procure, à un niveau de confiance de 95%, un intervalle de confiance de 13.

Tableau 5: Distribution des sondages envoyés par la poste et des sondages complétés reçus par langue

Envoyé FR	Envoyé ANG	**Envoyé Total**	Complété ANG	Complété FR	**Complété Total**
58	44	102	17	20	37

[1] 104 résidents/proches – 1 adresse aux États-Unis – 1 pour deux résidents ayant le même proche = 102

Analyse des données

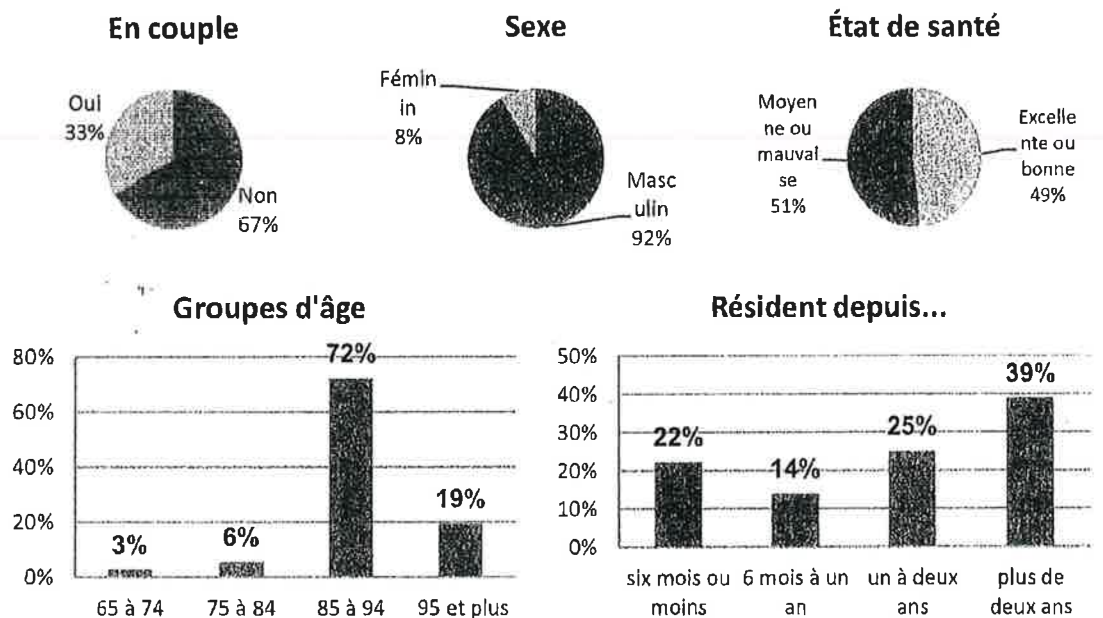
Puisque l'information recueillie auprès des proches et des familles ne peut être considérée comme un substitut aux réponses recueillies directement auprès des usagers, l'analyse de réponses obtenues s'est fait séparément pour chaque pavillon et mode d'administration du sondage.

La collecte des questionnaires et la saisie des données dans un fichier Excel ont été réalisées par l'équipe du service de la qualité. L'analyse des données s'est fait de la même façon que pour les données du pavillon principal (voir p.4).

Résultats

Données démographiques des répondants

Parmi les 36 répondants, presque tous les résidents représentés ont 85 ans ou plus (91%, n=33) et sont de sexe masculin (92%, n=33). La majorité des répondants résident à l'Hôpital Saint-Anne depuis plus d'un an (64%, n=23) en date du mois de novembre 2016.



Résultats : questions ouvertes et autres commentaires

L'analyse thématique des réponses obtenues au questions ouvertes et des commentaires exprimés par les répondants au courant du sondage a permis d'identifier plusieurs points positifs et points d'amélioration liés à la qualité de vie des résidents.

Qu'est-ce que vous aimez le plus à l'Hôpital Sainte-Anne?

Trois thèmes identifiés (nombre de commentaires recueillis à ce sujet):

- Personnel (Approche, respect, expertise, attention, gentillesse, etc.) (16)
- Qualité des soins et du milieu de vie (l'environnement, la sécurité, la qualité des soins) (13)
- Services (Services de soins spécialisés, activités, nourriture) (13)

Qu'est-ce qui pourrait être amélioré à l'Hôpital Sainte-Anne?

Quatre thèmes identifiés (nombre de commentaires recueillis à ce sujet):

- Réorganisation des services depuis le transfert fédéral - provincial (roulement du personnel, instabilité, formation, ressources, activités, qualité des soins etc.) (8)
- Personnel (roulement, plus de personnel, continuité des soins, formation, langue, communication personnel-famille) (15)
- Environnement (propreté, perte de biens personnels, délais de remplacement dentier) (5)
- Service et Activités (choix et qualité des repas, lessive, stimulation, aller dehors) (7)

Résultats : questions à choix multiples

Scores par thème (tableau 6) :

- Le respect par le personnel, la vie privée et la sécurité des résidents sont les thèmes qui globalement ont reçu les scores les plus élevés.
- Les relations interpersonnelles, les activités et l'autonomie sont les thèmes qui globalement ont reçu les scores les plus faibles. Considérant les limites cognitives de la clientèle du pavillon du souvenir, il est compréhensible que les relations interpersonnelles et l'autonomie des résidents soient plutôt restreintes.
- À noter que le thème de la nourriture et des repas, ayant reçu un score global assez positif de 13.9/20, a tout de même reçu plusieurs commentaires négatifs au sujet du non-respect des horaires, de l'offre en fruit et légumes frais, de la qualité et la variété des repas, ainsi que de l'aide aux repas.

Tableau 6: Scores moyens et standardisés par thème – pavillon du Souvenir

Thème (nombre d'items)	Moyenne	Écart type	Moyenne (intervalle de confiance de 95%)	Scores possibles	Scores moyens standardisés (sur 4.0)	Canada* (sur 4.0)
Respect par le personnel (4)	13.35	2.73	13.4 (12.4 to 14.3)	0-16	3.3	2.9
Vie privée (2)	6.24	1.53	6.2 (5.7 to 6.8)	0-8	3.1	3.2
Sécurité (3)	8.92	2.20	8.9 (8.2 to 9.7)	0-12	3.0	3.2
Réponse du personnel (4)	12.03	2.90	12.0 (11.1 to 13.0)	0-16	3.0	2.9
Nourriture et repas (5)	13.86	3.82	13.9 (12.6 to 15.1)	0-20	2.8	2.6
Lien résident-membres du personnel (5)	13.59	4.42	13.6 (12.1 to 15.1)	0-20	2.7	2.6
Confort (5)	11.92	3.05	11.9 (10.9 to 12.9)	0-20	2.4	2.5
Autonomie (7)	14.24	5.86	14.2 (12.3 to 16.2)	0-28	2.0	2.7
Activités (6)	11.97	4.48	12.0 (10.5 to 13.5)	0-24	2.0	2.7
Relations interpersonnelles (5)	6.35	5.14	6.4 (4.6 to 8.1)	0-20	1.3	2.0

*Source : Kehyayan et al., 2015

Résultats par item (tableau 7) :

- Toujours/La plupart du temps : 5 plus fréquents
    1. Traité avec respect – 91.9%
    2. Se sentir en sécurité – 86.5%
    3. Attention du personnel – 86.5%
    4. Recevoir soins requis – 86.5%
    5. Intimité respectée par le personnel – 83.8%

- Rarement/Jamais : 5 plus fréquents
    1. Occasion de nourrir liens affectifs – 57.6%
    2. Un autre résident est un ami proche – 62.2%
    3. Les gens me demandent aide ou avis – 59.5%
    4. Des gens avec qui faire des activités – 54.1%
    5. Facilité d'aller à l'extérieur – 43.2%

- Plus de 20% sans réponse ou non applicable
    - Occasions être avec d'autres qui partagent vision des choses – 24.3%
    - Activités religieuses disponibles – 24.3%
    - Donner suite aux suggestions – 24.3%
    - Facilité d'aller à l'extérieur – 21.6%
    - Développer nouvelles habiletés et nouveaux intérêts - 21.6%

L'analyse des résultats par item démontre encore une fois que l'approche attentionnée du personnel axée sur la sécurité, ainsi que la qualité des soins octroyés sont les points forts. De plus, tous les items avec les résultats les plus faibles sont liés au concept des relations interpersonnelles. Il est intéressant de noter que certains items ont un pourcentage assez élevé sans réponse (refus, ne sais pas, aucune réponse obtenue) ou sont indiqués comme non applicable par le répondant. Des explications à considérer sont l'intérêt des résidents envers l'item (ex : plusieurs ont exprimé que leurs proche n'était pas religieux) et la pertinence perçue de l'item pour cette clientèle (ex : ce n'est pas possible considérant l'état de mon père).

Tableau 7 : Perspective des résidents sur leur qualité de vie par thème et item – pavillon du Souvenir

Thème	Items	Toujours/La plupart du temps	Parfois	Rarement/ Jamais	Aucune réponse/NA
Vie Privée	Peux être seul	67.6% (25)	13.5% (5)	2.7% (1)	16.2% (6)
	Intimité respectée par le personnel	83.8% (31)	5.4% (2)	0% (0)	10.8% (4)
Nourriture et repas	Aliments préférés	43.2% (16)	40.5% (15)	5.4% (2)	10.8% (4)
	Manger quand voulu	59.5% (22)	16.2% (6)	16.2% (6)	8.1% (3)
	Repas variés	67.6% (25)	16.2% (6)	8.1% (3)	8.1% (3)
	Apprécie l'heure du repas	67.6% (25)	10.8% (4)	13.5% (5)	8.1% (3)
	Température des aliments	75.7% (28)	5.4% (2)	8.1% (3)	10.8% (4)
Sécurité	Obtenir l'aide requis	73.0% (27)	21.6% (8)	0% (0)	5.4% (2)
	Sécurité des effets personnels	64.9% (24)	16.2% (6)	13.5% (5)	5.4% (2)
	Se sentir en sécurité	86.5% (32)	0% (0)	8.1% (3)	5.4% (2)
Confort	Recevoir services requis	83.8% (31)	10.8% (4)	0% (0)	5.4% (2)
	Recommande l'hôpital	75.7% (28)	8.1% (3)	8.1% (3)	8.1% (3)
	Se sentir chez soi	62.2% (23)	10.8% (4)	16.2% (6)	10.8% (4)
	Facilité d'aller à l'extérieur	18.9% (7)	16.2% (6)	43.2% (16)	21.6% (8)
	Bruit incommodant	0% (0)	45.9% (17)	48.6% (18)	5.4% (2)
Autonomie	Peux prendre un bain ou une douche	21.6% (8)	16.2% (6)	43.2% (16)	18.9% (7)
	Décision de se lever	62.2% (23)	8.1% (3)	16.2% (6)	13.5% (5)
	Décision de se coucher	64.9% (24)	18.9% (7)	10.8% (4)	5.4% (2)
	Libre d'aller et venir	27.0% (10)	13.5% (5)	40.5% (15)	18.9% (7)
	Contrôle accès à la chambre	43.2% (16)	13.5% (5)	37.8% (14)	5.4% (2)
	Choix vestimentaire	32.4% (12)	18.9% (7)	37.8% (14)	10.8% (4)
	Décision occupations	54.1% (20)	13.5% (5)	24.3% (9)	8.1% (3)
Respect par le personnel	Traité avec respect	91.9 % (34)	2.7% (1)	0% (0)	5.4% (2)
	Attention du personnel	86.5% (32)	5.4% (2)	2.7% (1)	5.4% (2)
	Exprimer son opinion librement	67.6% (25)	16.2% (6)	0% (0)	16.2% (6)
	Respect des préférences	81.1% (30)	10.8% (4)	0% (0)	8.1% (3)
Réponse du personnel	Vivre comme je le veux	70.3% (26)	8.1% (3)	5.4% (2)	16.2% (6)
	Rapidité de la réponse du personnel	75.7% (28)	18.9% (7)	0% (0)	5.4% (2)
	Donner suite aux suggestions	51.4% (19)	21.6% (8)	2.7% (1)	24.3% (9)
	Recevoir soins requis	86.5% (32)	5.4% (2)	5.4% (2)	2.7% (1)
Lien résidents-membres du personnel	Personnel connait mon histoire de vie	64.9% (24)	13.5% (5)	13.5% (5)	8.1% (3)
	Membre du personnel est un ami	64.9% (24)	18.9% (7)	8.1% (3)	8.1% (3)
	Lien particulier avec un membre du personnel	37.8% (14)	21.6% (8)	21.6% (8)	18.9% (7)
	Conversations amicales avec le personnel	70.3% (26)	10.8% (4)	10.8% (4)	8.1% (3)
	Personnel m'interroge sur mes besoins	64.9% (24)	13.5% (5)	13.5% (5)	8.1% (3)
Activités	Activités plaisantes les fins de semaine	18.9% (7)	35.1% (13)	32.4% (12)	13.5% (5)
	Activités plaisantes les soirs	27.0% (10)	29.7% (11)	29.7% (11)	13.5% (5)
	Activités enrichissantes	24.3% (9)	24.3% (9)	37.8% (14)	13.5% (5)
	Activités religieuses disponibles	51.4% (19)	13.5% (5)	10.8% (4)	24.3% (9)
	Occasions être avec d'autres qui partagent vision des choses	35.1% (13)	13.5% (5)	27.0% (10)	24.3% (9)
	Développer nouvelles habiletés et nouveaux intérêts	24.3% (9)	21.6% (8)	32.4% (12)	21.6% (8)
Relations interpersonnelles	Un autre résident est un ami proche	21.6% (8)	5.4% (2)	62.2% (23)	10.8% (4)
	Les gens me demandent aide ou avis	18.9% (7)	10.8% (4)	59.5% (22)	10.8% (4)
	Occasion de nourrir liens affectifs	16.2% (6)	8.1% (3)	67.6% (25)	8.1% (3)
	Facile de se faire des amis	16.2% (6)	29.7% (11)	40.5% (15)	13.5% (5)
	Des gens avec qui faire des activités	16.2% (6)	16.2% (6)	54.1% (20)	13.5% (5)

Considérations éthiques

- **Approbation éthique :** le sondage s'est fait dans un contexte d'amélioration continue de la qualité, donc l'approbation du comité d'éthique de la recherche n'était pas nécessaire. Par contre, certaines considérations éthiques sont tout de même prises en compte dans l'administration du questionnaire.

- **Confidentialité** : Les sondages complétés n'incluent aucun identifiant personnel et sont conservés dans un bureau du service de la qualité au Centre Hospitalier St-Mary.

- **Participation volontaire** : la participation au sondage était volontaire. Des enveloppes de retour standardisées, sans identifiant, préadressées et préaffranchies ont été fournies.

No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

WOLF WILLIAM SOLKIN

Plaintiff

vs.

THE ATTORNEY GENERAL OF CANADA

-and-

THE ATTORNEY GENERAL OF QUEBEC

-and-

THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

LIST OF EXHIBITS AGC-1 TO AGC-25
IN SUPPORT OF THE DEFENCE
OF THE ATTORNEY GENERAL OF CANADA

EXHIBIT AGC-23

Attorney General of Canada

Department of Justice Canada
Québec Regional Office
Guy-Favreau Complex, East Tower, 9th Floor
200, René-Lévesque West Blvd.,
Montréal (QC) H2Z 1X4
Fax : (514) 283-3856 / NotificationPGC-AGC.Civil@justice.gc.ca

Per : Me Nathalie Drouin
Tel: (514) 283-8117
E-mail: Nathalie.drouin@justice.gc.ca

Per : Me Sébastien Gagné
Tel : (514) 283-7157
E-mail : Sebastien.gagne@justice.gc.ca

Per : Me Mariève Sirois-Vaillancourt
Tel : (514) 283-5553
Marieve.Sirois-Vaillancourt@justice.gc.ca

Per : Me Amélia Couture
Tel : (514) 283-6312
Amelia.Couture@justice.gc.ca

O/Ref : 9683661 BC0565

Ste. Anne's Hospital, Ste. Anne-de-Bellevue, QC

This document provides a summary of visits by Royal Canadian Legion (RCL) volunteers with Veterans at Ste. Anne's Hospital near Montreal between April 2016 and March 2019. The visits were carried out under Veterans Affairs Canada's Outreach and Visitation Initiative (OVI).

BACKGROUND

On April 1, 2016, the Government of Canada transferred Ste. Anne's Hospital to the province of Quebec.

Ste. Anne's Hospital can house 446 residents. Traditionally, WWII and Korean War Veterans were given priority access to beds. There is now a broader reach for Veterans, which includes access to both community and contract beds at Ste. Anne's Hospital. Quebec provincial authorities began admitting the first civilian patients at Ste. Anne's Hospital in April 2016.

As of March 31, 2019, there were 143 Veteran residents at Ste. Anne's Hospital (139 in contract beds, 4 in community beds).

With the exception of eligible war Veterans, the admission of other provincial residents is determined by the Government of Quebec. The allotment of beds, post-transfer, is determined by the Government of Quebec.

OUTREACH & VISITATION INITIATIVE

The Outreach and Visitation Initiative provides a mechanism by which the Department maintains contact with Veterans in long term care. Through a Contract for Service, the Department uses the Royal Canadian Legion Dominion Command volunteer network to conduct up to 5,000 visits annually with Veterans who are receiving financial assistance from the Department for long term care in facilities across Canada.

The initiative facilitates face to face visits with Veterans providing them with an opportunity to have a conversation and social visit with a volunteer. Volunteers record any discussion items raised by the Veteran related to his/her long term care arrangements, action taken (if applicable), and any follow-up (if required).

VISITS WITH VETERANS

For the 36 months from April 2016 to March 2019, RCL volunteers were tasked with 1,075 visits to Veterans at Ste. Anne's of which 990 (92%) visits were completed. Reasons why visits were not completed may include: Veteran had passed away; Veteran was not available on the day the volunteer visited the facility; Veteran was not capable of receiving a visitor or providing feedback; etc.

Of the 990 completed visits, RCL volunteers reported a total of eight (0.8%) discussion items raised by seven Veterans. Since completion of the visits, three of the seven Veterans have passed away.

<u>Discussion Item Categories</u>:

If a Veteran raises an item during the course of their visit and conversation with a RCL volunteer, the item may be referred to the RCL, to the facility, to the family/Power of Attorney, or to VAC to be addressed and/or for follow-up. Items raised may be grouped into one of the following categories:

1. Equipment - Veteran has equipment that is in need of repair or replacement.
2. File Update - VAC file needs updating (date of death, client location, phone #, etc.)
3. Facility Staff - Issues with facility staff (unprofessional, lack of services, understaffing, etc.)
4. Personal Care - Issues with personal care (ambulation, cleanliness, etc.)
5. Clinical Services - Issues with Clinical services (poor quality, lack of access).
6. VAC Coverage - Insufficient coverage, lack of coverage for a certain benefit or service.
7. Move Request - Veteran requested a transfer.
8. Health Care - Veteran's health status has changed, possibly requiring intervention.
9. Request for VAC Contact - Veteran/family member has requested information or a visit from VAC.
10. Other - Any items not covered by the other categories.

The 8 items raised as a result of visits at Ste. Anne's Hospital have been categorized as follows:

Discussion Item Category	**Number of Identified Discussion Items**	**For RCL**	**For Ste. Anne's**	**For Family/POA**	**For VAC**
Equipment	1				1
Facility Staff	6		6		
Other	1			1	
TOTAL:	**8**	**0**	**6**	**1**	**1**

Prepared by: John O'Brien, Senior Program Advisor, Health Care Programs Directorate
Date: July 5, 2019

No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

WOLF WILLIAM SOLKIN

Plaintiff

vs.

THE ATTORNEY GENERAL OF CANADA

-and-

THE ATTORNEY GENERAL OF QUEBEC

-and-

THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

LIST OF EXHIBITS AGC-1 TO AGC-25
IN SUPPORT OF THE DEFENCE
OF THE ATTORNEY GENERAL OF CANADA

EXHIBIT AGC-24

Attorney General of Canada

Department of Justice Canada
Québec Regional Office
Guy-Favreau Complex, East Tower, 9th Floor
200, René-Lévesque West Blvd.,
Montréal (QC) H2Z 1X4
Fax : (514) 283-3856 / NotificationPGC-AGC.Civil@justice.gc.ca

Per : Me Nathalie Drouin
Tel: (514) 283-8117
E-mail: Nathalie.drouin@justice.gc.ca

Per : Me Sébastien Gagné
Tel : (514) 283-7157
E-mail : Sebastien.gagne@justice.gc.ca

Per : Me Mariève Sirois-Vaillancourt
Tel : (514) 283-5553
Marieve.Sirois-Vaillancourt@justice.gc.ca

Per : Me Amélia Couture
Tel : (514) 283-6312
Amelia.Couture@justice.gc.ca

O/Ref : 9683661 BC0565

File Number: OMB-14344 **PROTECTED B**

Contact and File Information

Contact Information

Pref. Salutation:	Mr.	**VAC Client #:**	4730362
Full Name:	Wolf Solkin	**Service #:**	
Date of Birth:	1923/4/30	**Service Category:**	Traditional Veteran
Sex:	M		
Address:	305 des Anciens-Combattants Room T-11 / 14 Montreal-, Quebec H9X1Y9	**Consent to survey:**	
		Townhall Notification:	Not asked
Pref. Language:	English	**How did you hear about us:**	OVO website
Method of Contact:	Any		
Email:	wolfsolkin@icloud.com	**Modified On:**	2018/5/1
Primary Phone #:	(514) 505-3914	**Modified By:**	Lorne Allaire
Secondary Phone #:		**Stakeholder Risks:**	No
Contact Notes:			

File Information

Active/Closed:	File Closed	**Action Required:**	
File Type:	Complaint		
Priority:	Normal	**QA'd:**	No
Consent Provided:	Provided	**QA'd By:**	
Origin:	Email		
Recieved Date	2015/5/26	**Web Ref #:**	
Created On:	2015/5/26	**Physical File:**	
Created By:	Lorne Allaire		
Assigned Date:	2015/5/27		
Closed Date:	2015/9/8		

File Detail

Intake Note

Email from Mr. Solkin follows:
~~~~

I am a WW II Veteran, now in "permanent" residence at Ste. Anne's Hospital . I was a member/director of the soon-to-be outgoing Residents' Committee , plus having been the creator, writer and Editor-in-Chief of "The Veterans' Voice", an innovative , in-house newsletter dedicated to the cause and concerns of the Veteran population quartered at Ste. Anne's.
~~~~

I am now a candidate for the office of president of the SAH Residents' Committee. The election date is set for May 29/15, and therefore I wish to go on record with my complaint before that date, "win, lose, or draw", so that it may not be misconstrued as a matter of " sour gripes ", should the end result not be in my favour. While reluctant to bring this issue to the fore before now, I have finally permitted principle to prevail over politesse.

After my nomination document was properly submitted, I received a call requesting that I meet with the official volunteer (Mme Mychele Amberg) selected as "Election Returning Officer". Also present were Mme Nancy Latour, a staff member designated to be "Deputy Returning Officer"/Secretary, and Mme Joanne Grondin, another staff member, who had been appointed by "Management", as a (rotational) temporary Ombudsman, in situ.

The purpose of that meeting was to present me with a typed document, signed by the Returning Officer and her Deputy, which was titled as follows:
"2015-2018 Elections - Residents' Committee
Information on the election/campaign process for presidential candidates".

The contents of the a/m document was, in essence, a short set of fairly straightforward rules and regulations governing such items as: conduct of the election process; permitted size of written campaign/election notices; date and place(s) of voting; and the like. Those stipulations and conditions were then discussed on an item-by-item basis, and subsequently accepted .

At no time did the document itself, nor any of part of the discussion related to it, make any reference whatsoever to restrictions of any kind or nature pertaining to the subject matter/ content, wording, writing style , tone. etc., of the "text" of the permitted "election notice" (i.e., campaign flyer). The only stated submission requirements were/are that it be " ... a bilingual text with a maximum of 300 words written by the candidate to be submitted to the election secretary no later than May 15, 2015 (and)...can be printed in format 8.5 x 11...so that candidates can distribute them...".

Shortly after having submitted the text of my election notice/flyer in full accordance with all the declared conditions quoted and/or referred to above, I was summarily summoned to the office of Mme Rachel Gravel, the current Executive Director of Sre. Anne's Hospital, who informed me, in no uncertain terms, that under no circumstances would she ever allow my election notice, as originally conceived and duly submitted by me, to be printed by her Communications and Commemoration Directorate, let alone be posted and/or circulated anywhere in (her) hospital !

[Note that the main theme of my thesis was the impending injurious effects upon Ste. Anne's Hospital and its vulnerable Veterans, of the upcoming transfer from Federal to Provincial/Quebec command and control].

I admit to having been more than merely taken aback by what I deemed to be such an egregiously unilateral and autocratic decision (which I believe/d to be both unwarranted and unlawful). When I asked to know the reasons for her unyielding draconian stance, Mme Gravel told me (and I both paraphrase and quote, to the best of my nonagenarian capacity for recall), that she personally considered the wording and tone of my text to be entirely too improper and unacceptably confrontational, aggressive , and denigrating toward The Province of Quebec and its Health Department. Nor was I to make reference to what are (in my opinion and that of others) the lower standards of care, poorer staff-to-patient ratios, and less professionally effective protocols under the aegis of Quebec, than are to be found within our current Federal governance.

Mme Gravel's other major objection was that she was convinced my envisioning and portraying future damoclean problems and concerns affecting my fellow-resident/patients, which disruptive difficulties I am confident will be spawned by the forthcoming transfer/transition of Ste, Anne's Hospital from Federal to (Quebec's) Provincial jurisdiction, would only serve to make our Residents and their families anxious and disquieted about their future fate. It should, perhaps be noted here that my views are, coincidentally, diametrically opposed to the position manifested in a recent letter from Mme Gravel to all patients' families, expressing her open optimism, coupled with her emphatic assurances of a virtually seamless transition, which would patently redound to the benefit of all souls involved, and so the transfer need not be feared as a threat to anyone, all as personally vouchsafed by her.

When I inquired as to what were my options , Mme Gravel unhesitatingly and firmly replied that I could agree to re-write my election notice/flyer in bowdlerized form to her personal satisfaction, i.e., deleting any and all, in her own opinion, so-called negative , controversial, provocative or disturbing references to a possible tsunami of transfer-transition troubles, and replace them with more reassuring and positive material***. If I were unwilling to comply with that directive, I could then elect (pun notwithstanding) to conduct my election campaign without the aid of any supporting printed material whatsoever. Failing that course of (in)action, of course the final option would appear to be clearly inevitable (even to one at my advanced age and stage).

Which finally(!) brings me to the complaint which I now must needs draw to your attention : I am of the conviction that Mme Rachel Gravel, in her Federal civil-service employee capacity as Executive Director of Ste. Anne's Hospital, has, as displayed in her above-described conduct toward me, far exceeded the defined and mandated authority, powers and limitations of the official job description of her position and government employee classification or category, and that she should therefore be subject to whatever action s are indicated, in accordance with the applicable CVA prevailing process and protocols,should my contention indeed prove to be upheld.

On the other hand, if it is determined that I am wrong on all counts in my assumptions, and my complaint is wholly unfounded in the ruling /opinion of the VAC Ombudsman, I will unhesitatingly personally apologize and grovel before Gravel, for having wrongfully complained about her a/m actions toward me.

I have here attempted, insofar as possible for me , to present the straight facts, avoiding I.
Pany undue enhancement of the case by injecting my emotional response to what I objectively consider to be an outright and blatant violation of my rights and privileges, as delineated for the treatment of Veterans by VAC employees in the applicable DVA "charter" of yore; let alone as an ordinary Canadian citizen, for whose rights to freedom of speech and of expression many of us once fought so fiercely to protect and preserve.

***I ultimately decided, under both pressure and protest, to "choose door no.1", perforce putting pragmatism before principle and pride, if I might yet have the opportunity to effectively craft beneficial changes from within the existing structure and venue, rather than be limited to punier progress by protest from beyond the pale.

You have my permission to access my VAC file, and I will genuinely appreciate your anticipated response.

Respectfully,

Wolf William Solkin
Ste. Anne's Hospital
Room T-11 / 14
VAC file no. K4730362
tel. (514) 505-3914
<wolf solkin@icloud.com>

Sent from my iPad
~~~~

Issue

Executive Director of Ste. Annes Hospital overstepped her mandate and authority as a pulic servant.

Category/Program: Canada Remembers

Issue Type: Bill of Rights

Communication Notes

Date communication occurred: 2015-11-09 3:19 PM	**Communication Contact Data**
Communication method: Email	**First name:** Wolf
Communication to / from: From	**Last name:** Solkin
Contact:	**Organization:**
Type of note: Communication with Stakeholder	**Position:**
Created on: 2015-11-09 3:19 PM	**Business phone:**
~~~~

Created by: Lorne Allaire | **Email:** wolfsolkin@icloud.com

Details

Email from Mr. Solkin follows and is attached:

~~~

[THIS IS TO ACCOMPANY MY LETTER TO MICHEL DOIRON, OF NOVEMBER 2, 2015]

Please provide copy to Mr. Guy Parent.

Sent from my iPad

Begin forwarded message:

> From: Wolf Solkin <wolfsolkin@icloud.com>
> Date: October 2, 2015 at 7:17:29 AM GMT-4
> To: Louise Solkin <louiselanglois.s@gmail.com>
> Subject: OUTCOME of OFFICIAL COMPLAINT by W. W. SOLKIN TO VAC OMBUDSMAN
>
> To all those parties whom this matter may concern:
>
> This statement is being prepared today, October 2nd, 2015, (but held back for distribution until after Oct.9/15), in anticipation of the forthcoming receipt of the official adjudication of my formal complaint, filed on May 27/15, with the Ombudsman of Veterans Affairs Canada, against Mme Rachel Gravel, Executive Director of Ste, Anne's Hospital. Said complaint pertains to certain aspects of Mme Gravel's conduct and actions toward me, which I maintain far exceeded the official mandate/authority of her civiil service position parameters, by suppressing some of my inherent rights as a patient at Ste. Anne's, and also violating my civil rights, as defined in Canada's Charter of Rights and Freedoms (i.e., freedom of thought, belief, opinion and freedom of expression).
>
> The purpose of this memorandum is to go on record, in advance, as to my prediction, assertion and firm conviction that the outcome of the a/m complaint will, as a foregone conclusion, reject the validity and/or justification of my contention(s),plus my request for rectification/vindication, and that, regardless of the true facts of the case, the ruling is pre-ordained to go against me, if for no other reason than that it would hardly do for VAC to suffer embarrassment by rendering a negatively critical statement denigrating "one of their own", particularly in light of her having been recently named (and proudly publicized by VAC) as its recipient of the 2015 "Public Service Employee Award Of Excellence".....presented, no less, by the Governor General at Rideau Hall.
>
> I recognize the sensitivity of the position in which VAC found itself, albeit I am deeply disappointed in how it saw fit to prioritize its components.
>
> Enough said.
>
> Please thank Mr. Michel Doiron for his consideration andi courtesy.
>
> Sincerely,
>
>
> Wolf William Solkin.
>
> Sent from my iPad

Communication Note Attachment

Attachment: Yes

Created on:

Attachment File Description

Date communication occurred: 2015-11-09 3:18 PM

Communication method: Email

Communication to / from: From

Contact:

Communication Contact Data

First name: Wolf

Last name: Solkin

Organization:
~~~

Type of note: Communication with Stakeholder	Position:
Created on: 2015-11-09 3:18 PM	Business phone:
Created by: Lorne Allaire	Email: wolfsolkin@icloud.com

Details

Email as received from Mr. Solkin follows and is attached:
~~~

Dear Mr. Doiron

This in response your official letter to me, of Oct.19,2015, in which you wrote that I need not hesitate to contact you should I "wish to discuss further". By that, I presume you referred to your
ruling against the validity of my complaint that my inherent and proclaimed rights, as a resident/patient at Ste. Anne's Hospital (SAH), and as a Canadian citizen, to freedom of thought, belief, opinion and freedom of expression, were violated by the actions of the SAH Executive Director, (all as outlined in my formal complaint letter to the Veterans Ombudsman dated May 27/15, and elaborated upon at our only meeting, in Aug/15).

From the content and finality of tone in your letter, I do not believe there to be any point to holding anything resembling a "discussion" which might serve any productive purpose, as it is, of course, impossible to quantify, prove or disprove the all too familiar SAH management's ubiquitous "fire wall" mantra/bugaboo about (potential) vague and looming medical/health consequences. I will, however, take advantage of your invitation, to express some of my observations and comments on your decision. When we met, you told me that my letter of complaint had first been jointly considered/discussed by the Ombudsman and the Deputy Minister of Veterans Affairs Canada (VAC), who then called on you to interview me in order to obtain, first hand, a more in-depth view of the situation, following which you were to present your report to them for their study, so that they would be better enabled to render their ruling.

Accordingly, I was nonplussed to realize that not only did you conduct the inquiry, but you also seem to have personally determined the conclusive judgement, and only then did you submit what appears to be an "FYI" copy of same to Mr. Guy Parent (but not, it seems, to General Walter Natynczyk).
Then again, I note, in your cover email to me, you wrote that you were providing me with..."a copy of my (i.e., your) response to the complaint you (i.e., I) had lodged through the Office of the Veterans Ombudsman-file number OMB15-014344. I have copied Mr. Parent on this e-mail, so he is aware and can update his file". Hardly the procedure I was led to expect.

I am also puzzled by the fact that when I asked you if you were a member of the Ombudsman's Office, you hastened to disabuse me of any such impression, clearly stating that, to the contrary, you are the "Associate Deputy Minister for Service Delivery", which role entailed several other/ different functions; And yet, notwithstanding, the final verdict was apparently rendered by you, rather than by an accredited official in the Ombudsman's Office, as I had anticipated by so addressing my initial letter of complaint.

You also wrote that you conducted "a thorough review of the case...and a visit to SAH to gather facts and to interview principle (sic) parties". I am curious as to whether you interviewed the Chief Returning Officer and/or her Deputy, who were directly involved parties. More to the point, were you able find time, during your investigation, to interview a proper statistical sampling of what you termed as "...the greater resident population", within which my " strongly worded (initial flyer) had the potential to cause concern..." ?

It appears to me, from your letter, that you virtually acknowledge, in your words..."that (my) personal rights were infringed...", albeit you seemingly concluded that Mme Rachel Gravel's behaviour toward me, as but one lone individual, was correct and justified in overriding the fundamental fact of my institutional and constitutional rights, on the the sacrificial altar of the greater number, "in support of the hospital's general population".

As an interesting aside, some of your letter's explanatory/justifying words and phrases are readily reminiscent of those with which I have been consistently confronted heretofore by Mme Gravel's traditional "talking points", particularly whenever I protested against the Province's present and/or potential inferior protocols, which she seems so prone to protect from criticism, and which is the predominant cause of my less-than-passive posture, in my efforts to safeguard the future treatment of my fellow-Veterans, as they risk becoming transformed into Provincial ciphers.

Your letter expressed your "...trust (that your decision) brings this matter to a close...". I must confess it is difficult for me to concur with you at this time, as I continue to have lingering doubts, not only about the validity of your conclusion , but also the process and personnel engaged in its formation.
~~~

I might well be considered Quixotic in my tilting at the windmills of government bureaucracy and its circle-the-wagons reflexive tactics, but then again, not all windmills are inevitably indestructible, nor inexorably impregnable against the arsenal of public protestation, in defence of one's prized principles and sacrosanct rights.

Regardless of your declared decision /opinion, I am not only a proud Canadian Veteran now living out my life at Ste. Anne's Hospital, under its Charter of Resident's Rights and Responsibilities, but, perhaps of even greater import, is that I am also a proud Canadian Citizen, now living out my life in the country for which I had once voluntarily fought, under the Canadian Charter of Rights and Freedoms, which is above individual, subjective interpretation and dismissal, let alone rescindment..

As Mr. Guy Parent himself recently and openly urged us Veterans..."Go for it, and continue to free the facts"! Sounds like a sound idea !

In conclusion, and by way of demonstrating /verifying that today's email is not a matter of post-facto "sour gripes", I am also sending you, under separate cover, copy of an earlier email I had composed for the attention of the VAC Ombudsman Office , and which I sent to my wife (to withhold), on October 2nd, 2015, well in advance of receipt of your "decision letter " (of Oct.19/15). I did so, purely as a matter of record, to establish that I was already certain that the outcome of my complaint could/would not be in my favour, under any circumstances , regardless of the "facts" which Mr. Parent so eloquently encouraged all Veterans to (set) "free".

I consider the latter communication to be a true harbinger of the treatment my complaint would necessarily receive, regardless of what I, in my very core, hold to be the unquestionable validity of my complaint, which you, in your own view, saw fit to deem as being unworthy of upholding.

Will you please provide Mr. Guy Parent with a copy of this entire correspondence, as I do not have his email address.

Yours truly,

Wolf William Solkin.

Sent from my iPad

Communication Note Attachment	**Attachment File Description**
Attachment: Yes **Created on:**	

Date communication occurred: 2015-10-21 9:09 AM	**Communication Contact Data**
Communication method: Email	**First name:** Guy
Communication to / from: Other	**Last name:** Parent
Contact:	**Organization:** OVO - Ottawa
Type of note: Communication with VAC/BPA/VRAB	**Position:** Veterans' Ombudsman
Created on: 2015-10-21 9:09 AM	**Business phone:** (613) 944-2950
Created by: Lorne Allaire	**Email:** Guy.Parent@ombudsman-veterans.gc.ca

Details

>>>
From: Guy Parent
To: Cory Micalef; Michel Doiron
Date: 2015/10/21 8:49 AM
Subject: Re: MY FORMAL COMPLAINT TO THE OMBUDSMAN

Merci Michel,
J`espère qu`il sera satisfait.
Guy

Guy Parent
Veterans Ombudsman | Ombudsman des vétérans
Office of the Veterans Ombudsman | Bureau de l'ombudsman des vétérans
Ottawa, Canada
Guy.Parent@ombudsman-veterans.gc.ca
Telephone | Téléphone: 613-944-2950
Facsimile | Télécopieur:613-944-2939
www.ombudsman-veterans.gc.ca
Government of Canada | Gouvernement du Canada
>>> Michel Doiron 2015/10/19 3:11 PM >>>
Mr. Solkin,
Again, please accept my deepest regrets for this delay. Attached please find a copy of my response to the complaint you had lodged through the Office of the Veterans Ombudsman - file number OMB15-014344. I have copied Mr. Parent on this e-mail, so he is aware and can update his file.

I truly hope this information brings the matter to a close for you but please do not hesitate to contact me should you wish to discuss further.

Sincerely, Michel

Michel D. Doiron
Assistant Deputy Minister, Service Delivery Branch / SMA, Secteur de la prestation des services
Veterans Affairs Canada / Anciens Combattants Canada
P.O. Box 7700 / C.P. 7700
Charlottetown, PE C1A 8M9 / Charlottetown, Î.-P.-É. C1A 8M9
Telephone / Téléphone (902) 626-2723 / michel.doiron@vac-acc.gc.ca / Facsimile / Télécopieur (902) 566-8172
Government of Canada / Gouvernement du Canada
http://www.veterans.gc.ca/

>>> Michel Doiron 2015/10/16 11:41 AM >>>
Mr. Solkin,

Please accept my sincere apologies for the delay. I have been out of the office on sick leave, but will provide you with a formal response on Monday.

Michel

Michel D. Doiron
Assistant Deputy Minister, Service Delivery Branch / SMA, Secteur de la prestation des services
Veterans Affairs Canada / Anciens Combattants Canada
P.O. Box 7700 / C.P. 7700
Charlottetown, PE C1A 8M9 / Charlottetown, Î.-P.-É. C1A 8M9
Telephone / Téléphone (902) 626-2723 / michel.doiron@vac-acc.gc.ca / Facsimile / Télécopieur (902) 566-8172
Government of Canada / Gouvernement du Canada
http://www.veterans.gc.ca/

>>> Wolf Solkin <wolfsolkin@icloud.com> 2015/10/16 9:52 AM >>>
Good morning, Mr. Doiron...
Today marks one week to the day, that your last email to me (Sept.30/15) led me, as you wrote, to "expect to have the response (to my formal complaint of May 27/15) ready and sent by Friday, Oct. 9, 2015". I therefore feel I am not being unduly forward in requesting that you now please inform me as to the precise present status of that response, and when I can truly expect to have the final document in my possession.

Whatever the reason for this regrettable delay, I cannot mask my deep disappointment at its occurrence. I do trust that you will now reply to me in timely fashion.

Your courtesy and cooperation in this regard will be most appreciated.

Respectfully,

Wolf William Solkin
Ste. Anne's Hospital
Ste. Anne de Bellevue, PQ.
(514) 505-3914
<wolfsolkin@icloud.com>

Sent from my iPad

Communication Note Attachment	Attachment File Description
Attachment: Yes **Created on:**	

Date communication occurred: 2015-09-09 4:20 PM	Communication Contact Data
Communication method: N/A	**First name:** Cory
Communication to / from: Other	**Last name:** Micalef
Contact:	**Organization:** OVO - Early Intervention
Type of note: IO Recommendation	**Position:** Manager, Early Intervention
Created on: 2015-09-09 4:20 PM	**Business phone:** (902) 368-0075
Created by: Lorne Allaire	**Email:** cory.micalef@ombudsman-veterans.gc.ca

Details

Complaint handling taken over by the Deputy Minister. Close file.

Communication Note Attachment	Attachment File Description
Attachment: No **Created on:**	

Date communication occurred: 2015-07-30 1:17 PM	Communication Contact Data
Communication method: Email	**First name:** Wolf
Communication to / from: From	**Last name:** Solkin
Contact:	**Organization:**
Type of note: Communication with Stakeholder	**Position:**
Created on: 2015-07-30 1:17 PM	**Business phone:**
Created by: Lorne Allaire	**Email:** wolfsolkin@icloud.com

Details

Email from Mr. Solkin follows and is attached:
~~~
Hello, Mr. Micalef...
I am sending this simply to inquire whether you received (in good/legible condition) the two emails I sent to you on July 22/15, as my iPad has been misbehaving lately.

One email contained text plus an attachment, and the other had text only.

Do please reply and let me know whether I should re-send one or both items., as had been verbally requested by you.

Respectfully,
~~~

Wolf William Solkin.

Sent from my iPad

Communication Note Attachment	Attachment File Description
Attachment: Yes **Created on:**	

Date communication occurred: 2015-07-30 1:13 PM	**Communication Contact Data**
Communication method: Email	**First name:** Wolf
Communication to / from: From	**Last name:** Solkin
Contact:	**Organization:**
Type of note: Communication with Stakeholder	**Position:**
Created on: 2015-07-30 1:13 PM	**Business phone:**
Created by: Lorne Allaire	**Email:** wolfsolkin@icloud.com

Details

Email as received from Mr. Solkin follows and is attached:
~~~
Dear Sir...below is a reproduction of the final "approved " (by Mme Rachel Gravel) version of the "Election Notice"/Flyer which I was eventually permitted to use in the recent election for President of the Ste. Anne's Hospital Residents'Committee (except for typo reversal of my given names).

This will be followed by a second email containing a copy of the previous /original version, which Mme Gravel had refused to allow under any circumstances, which action I deem to have been unwarranted and, more important,an unauthorized and unlawful violation of my rights as a Resident-Veteran at Ste. Anne's, let alone as a Canadian citizen,in addition to being far in excess of her mandated civil service position at Veterans Affairs Canada.

If there is any problem in your receipt of this and/or the succeeding email, please advise.

Many thanks for your prompt attention to this complaint.

Respectfully,

Wolf William Solkin.

| Communication Note Attachment | Attachment File Description |
|---|---|
| **Attachment:** Yes<br>**Created on:** | |

| **Date communication occurred:** 2015-07-30 1:11 PM | **Communication Contact Data** |
|---|---|
| **Communication method:** Email | **First name:** Wolf |
| **Communication to / from:** From | **Last name:** Solkin |
| **Contact:** | **Organization:** |
| **Type of note:** Communication with Stakeholder | **Position:** |
| **Created on:** 2015-07-30 1:11 PM | **Business phone:** |
| **Created by:** Lorne Allaire | **Email:** wolfsolkin@icloud.com |

**Details**
~~~

Email recived from Mr. Solkin follows and is attached:

~~~

Attention Mr. Cory Micalef....below is the (much bowdlerized and abridged) original version of the Election Notice/Flyer which I submitted to the Secretary of the Election Committee for printing and distribution, but which was adamantly and arbitrarily rejected by Mme Rachel Gravel , all as outlined to you in my initial complaint letter, largely due to my own personal comments, concerns and misgivings regarding the effects upon Ste. Anne's Hospital and its Resident-Veterans, of the forthcoming transfer from Federal to (Quebec) Provincial jurisdiction, which I felt it necessary and important to share with my comrades.

Mme Gravel told me, among other things, that she objected to my negative/disrespectful/deprecating statements about the standards and protocols of Quebec's Health Department., albeit that was the principal purpose and thrust of my thesis.

Do please let me know if I can be of any further assistance in this, to me, so vital an issue that I am prepared to risk possible reprisals /consequences for having initiated this complaint.

Respectfully,

Wolf William Solkin.

Sent from my iPad

Begin forwarded message:

> Subject: Fwd: WW SOLKIN TEXT FOR ELECTION NOTICE (English).....under 300 words; if not, PLS.ADVISE !
>
>
>
> Sent from my iPad
>
> Begin forwarded message:
>
>> From: Wolf Solkin <wolfsolkin@icloud.com>
>> Date: May 14, 2015 at 11:17:56 AM GMT-4
>> To: Nancy Latour <Nancy.Latour@vac-acc.gc.ca>
>> Subject: WW SOLKIN TEXT FOR ELECTION NOTICE (English).....under 300 words; if not, PLS.ADVISE !
>>
>> WOLF WILLIAM SOLKIN: Served as Editor in Chief of "the Veterans' Voice", and Director of the Residents' Committee. Respectfully asking for your vote to elect me as President, so I can continue in your service, especially during the difficult transfer/transition times ahead.
>>
>> #Served in combat as Lieutenant with The Algonquin Regiment in Holland and Germany, until V-E Day and beyond.
>>
>> #Bachelor of Arts, McGill University; Master of Social Work, University of Toronto.
>>
>> We now enjoy"the good life": excellent health care, experienced employees, entertainments, etc., and I am determined to fight to maintain our present level of care and standard of living, and fulfil all other mandated responsibilities of the President.
>>
>> BUT, we are now on the precipice of a very steep cliff, and we'll soon be pushed over into the pit of Quebec's Department of Health, with its poorer protocols of care, staff and services,waiting to infiltrate our lines and our lives.
>>
>> I am convinced, in spite of assurances by Veterans Affairs Canada (VAC) that our standards of care will not be diminished, that once Quebec gains control they will shaft us, unless we take our heads out of the sand of silence, and speak up for ourselves, loud and clear, to the politicians and the public...and it will be my duty to "take the point"!
>>
>> For the next two to three years of the transition, we are going to have one helluva fight on our hands to preserve our way of life and protect what is rightly ours, against our new masters. That very fight is precisely what I am
~~~

committed to undertake for my SAH comrades, in cooperative harness with a revitalized Residents' Committee, with my leadership as its President.
>>
>>
>>
>> YOUR VOTE WILL BE MUCH APPRECIATED
>>
>> WOLF WILLIAM SOLKIN
>>
>>
>> Sent from my iPad

Communication Note Attachment	**Attachment File Description**
Attachment: Yes	
Created on:	

Date communication occurred: 2015-07-30 1:07 PM	**Communication Contact Data**
Communication method: Email	**First name:** Wolf
Communication to / from: From	**Last name:** Solkin
Contact:	**Organization:**
Type of note: Communication with Stakeholder	**Position:**
Created on: 2015-07-30 1:07 PM	**Business phone:**
Created by: Lorne Allaire	**Email:** wolfsolkin@icloud.com

Details

Via email, from Mr. Solkin:
~~

Dear Sir...below is a reproduction of the final "approved " (by Mme Rachel Gravel) version of the "Election Notice"/Flyer which I was eventually permitted to use in the recent election for President of the Ste. Anne's Hospital Residents'Committee (except for typo reversal of my given names).

This will be followed by a second email containing a copy of the previous /original version, which Mme Gravel had refused to allow under any circumstances, which action I deem to have been unwarranted and, more important,an unauthorized and unlawful violation of my rights as a Resident-Veteran at Ste. Anne's, let alone as a Canadian citizen,in addition to being far in excess of her mandated civil service position at Veterans Affairs Canada.

If there is any problem in your receipt of this and/or the succeeding email, please advise.

Many thanks for your prompt attention to this complaint.

Respectfully,

Wolf William Solkin.

Communication Note Attachment	**Attachment File Description**
Attachment: Yes	
Created on:	

Date communication occurred: 2015-07-29 10:53 AM	**Communication Contact Data**
Communication method: Email	**First name:** Guy
Communication to / from: From	**Last name:** Parent
Contact:	**Organization:** OVO

Type of note: Communication with Stakeholder	Position: Veterans' Ombudsman
Created on: 2015-07-29 10:53 AM	Business phone: (613) 944-2950
Created by: Lorne Allaire	Email: Guy.Parent@ombudsman-veterans.gc.ca

Details

From: Guy Parent
To: Cory Micalef; Guay, Michel
CC: Liisa Blagden; Sharon Squire
Date: 2015/07/29 9:42 AM
Subject: Mr S. SAH case

Hi Michel,
Documents concerning the above case were hand delivered by myself to Deputy Minister Veterans Affairs Canada yesterday afternoon. The DM accepted the case and indicated that he will be taking action, and that we will be informed of the outcomes.
Cory, could you please enter a note to that effect in the file.
thanks
Guy

Guy Parent
Veterans Ombudsman | Ombudsman des vétérans
Office of the Veterans Ombudsman | Bureau de l'ombudsman des vétérans
Ottawa, Canada

Communication Note Attachment	Attachment File Description
Attachment: Yes	
Created on:	

Date communication occurred: 2015-07-24 9:23 AM	Communication Contact Data
Communication method: Phone	First name: Wolf
Communication to / from: To	Last name: Solkin
Contact:	Organization:
Type of note: Communication with Stakeholder	Position:
Created on: 2015-07-24 9:23 AM	Business phone:
Created by: Lorne Allaire	Email: wolfsolkin@icloud.com

Details

Call to the Veteran to inform him that we received his email with the information we requested. I told him that I gave copy of his complaint and the additional information he provided to my Director and the Ombudsman for their action. The Veteran said he was extremely pleased with us following up on the matter and the efficient service we have provided him.

Communication Note Attachment	Attachment File Description
Attachment: No	
Created on:	

Date communication occurred: 2015-07-23 10:50 AM	Communication Contact Data
Communication method: Email	First name: Guy
Communication to / from: To	Last name: Parent
Contact:	Organization: OVO

Type of note: Communication with Stakeholder	Position: Veterans' Ombudsman
Created on: 2015-07-23 10:50 AM	Business phone: (613) 944-2950
Created by: Lorne Allaire	Email: Guy.Parent@ombudsman-veterans.gc.ca

Details

>>>
From: Cory Micalef
To: Guay, Michel; Parent, Guy; Squire, Sharon
Date: 2015/07/23 10:28 AM
Subject: Wolf Solkin Complaint

Good morning,

Herewith attached is the information we requested from the Veteran as well as the complaint submitted to the OVO.

Solkin Flyer
Page 1 : Email to me

End of page 1 and 2: The initial content he submitted by email to be printed on the flyer that was subsequently not permitted.

Page 3 : The final flyer

Solkin Letter
The complaint letter sent to the OVO.

If you need additional information please let me know.

Communication Note Attachment	Attachment File Description
Attachment: Yes	
Created on:	

Date communication occurred: 2015-07-21 4:17 PM	Communication Contact Data
Communication method: Phone	First name: Wolf
Communication to / from: To	Last name: Solkin
Contact:	Organization:
Type of note: Communication with Stakeholder	Position:
Created on: 2015-07-21 4:17 PM	Business phone:
Created by: Lorne Allaire	Email: wolfsolkin@icloud.com

Details

Call to the Veteran to request that he send us a copy of the content he submitted to be printed on the pamphlet that was to be distributed for the election for President of the residents of Sainte -Anne Hospital. The Veteran said he was very pleased that the OVO is following up in the matter.
He said he is more than willing to provide us with the information. He said he will send both the initial content he submitted that was refused, as well as the "acceptable" version that was printed on the pamphlet.

Communication Note Attachment	Attachment File Description
Attachment: No	
Created on:	

Date communication occurred: 2015-06-17 1:40 PM	Communication Contact Data
Communication method: Phone	First name: Wolf

Communication to / from: To	Last name: Solkin
Contact:	Organization:
Type of note: Communication with Stakeholder	Position:
Created on: 2015-06-17 1:40 PM	Business phone:
Created by: Lorne Allaire	Email: wolfsolkin@icloud.com

Details

The Veteran explained that his rights to free speech were violated and that he was not treated with respect as per the Veteran Bill of Rights. He said as a candidate for the election he submitted the information to be printed on the leaflet as required. He was told by the civil servant in charge that she will in no way let that leaflet circulate in her hospital. He added that she overstepped her mandate and treated him without respect as a citizen and a Veteran.
He would like her to be reprimanded and that the scope of her mandate be clarified to her. I informed the Veteran that I would look into the matter and get back to him.

Communication Note Attachment	Attachment File Description
Attachment: No	
Created on:	

Date communication occurred: 2015-06-17 1:33 PM	Communication Contact Data
Communication method: Email	First name: Wolf
Communication to / from: From	Last name: Solkin
Contact:	Organization:
Type of note: Consent - Provided	Position:
Created on: 2015-06-17 1:33 PM	Business phone:
Created by: Lorne Allaire	Email: wolfsolkin@icloud.com

Details

Consent given to read VAC files and to communicate with VAC on his/her behalf, as needed.

Communication Note Attachment	Attachment File Description
Attachment: No	
Created on:	

Date communication occurred: 2015-05-27 2:21 PM	Communication Contact Data
Communication method: Email	First name: Wolf
Communication to / from: From	Last name: Solkin
Contact:	Organization:
Type of note: Communication with Stakeholder	Position:
Created on: 2015-05-27 2:21 PM	Business phone:
Created by: Lorne Allaire	Email: wolfsolkin@icloud.com

Details

Email as received from Mr. Solkin follows and is attached:
~~~

I am a WW II Veteran, now in "permanent" residence at Ste. Anne's Hospital . I was a member/director of the soon-to-be outgoing Residents' Committee , plus having been the creator, writer and Editor-in-Chief of "The Veterans' Voice", an innovative , in-house newsletter dedicated to the cause and concerns of the Veteran population quartered at Ste. Anne's.
~~~

I am now a candidate for the office of president of the SAH Residents' Committee. The election date is set for May 29/15, and therefore I wish to go on record with my complaint before that date, "win, lose, or draw", so that it may not be misconstrued as a matter of " sour gripes ", should the end result not be in my favour. While reluctant to bring this issue to the fore before now, I have finally permitted principle to prevail over politesse.

After my nomination document was properly submitted, I received a call requesting that I meet with the official volunteer (Mme Mychele Amberg) selected as "Election Returning Officer". Also present were Mme Nancy Latour, a staff member designated to be "Deputy Returning Officer"/Secretary, and Mme Joanne Grondin, another staff member, who had been appointed by "Management", as a (rotational) temporary Ombudsman, in situ.

The purpose of that meeting was to present me with a typed document, signed by the Returning Officer and her Deputy, which was titled as follows:
"2015-2018 Elections - Residents' Committee
Information on the election/campaign process for presidential candidates".

The contents of the a/m document was, in essence, a short set of fairly straightforward rules and regulations governing such items as: conduct of the election process; permitted size of written campaign/election notices; date and place(s) of voting; and the like. Those stipulations and conditions were then discussed on an item-by-item basis, and subsequently accepted .

At no time did the document itself, nor any of part of the discussion related to it, make any reference whatsoever to restrictions of any kind or nature pertaining to the subject matter/ content, wording, writing style , tone. etc., of the "text" of the permitted "election notice" (i.e., campaign flyer). The only stated submission requirements were/are that it be " ... a bilingual text with a maximum of 300 words written by the candidate to be submitted to the election secretary no later than May 15, 2015 (and)...can be printed in format 8.5 x 11...so that candidates can distribute them...".

Shortly after having submitted the text of my election notice/flyer in full accordance with all the declared conditions quoted and/or referred to above, I was summarily summoned to the office of Mme Rachel Gravel, the current Executive Director of Sre. Anne's Hospital, who informed me, in no uncertain terms, that under no circumstances would she ever allow my election notice, as originally conceived and duly submitted by me, to be printed by her Communications and Commemoration Directorate, let alone be posted and/or circulated anywhere in (her) hospital !

[Note that the main theme of my thesis was the impending injurious effects upon Ste. Anne's Hospital and its vulnerable Veterans, of the upcoming transfer from Federal to Provincial/Quebec command and control].

I admit to having been more than merely taken aback by what I deemed to be such an egregiously unilateral and autocratic decision (which I believe/d to be both unwarranted and unlawful). When I asked to know the reasons for her unyielding draconian stance, Mme Gravel told me (and I both paraphrase and quote, to the best of my nonagenarian capacity for recall), that she personally considered the wording and tone of my text to be entirely too improper and unacceptably confrontational, aggressive , and denigrating toward The Province of Quebec and its Health Department. Nor was I to make reference to what are (in my opinion and that of others) the lower standards of care, poorer staff-to-patient ratios, and less professionally effective protocols under the aegis of Quebec, than are to be found within our current Federal governance.

Mme Gravel's other major objection was that she was convinced my envisioning and portraying future damoclean problems and concerns affecting my fellow-resident/patients, which disruptive difficulties I am confident will be spawned by the forthcoming transfer/transition of Ste, Anne's Hospital from Federal to (Quebec's) Provincial jurisdiction, would only serve to make our Residents and their families anxious and disquieted about their future fate. It should, perhaps be noted here that my views are, coincidentally, diametrically opposed to the position manifested in a recent letter from Mme Gravel to all patients' families, expressing her open optimism, coupled with her emphatic assurances of a virtually seamless transition, which would patently redound to the benefit of all souls involved, and so the transfer need not be feared as a threat to anyone, all as personally vouchsafed by her.

When I inquired as to what were my options , Mme Gravel unhesitatingly and firmly replied that I could agree to re-write my election notice/flyer in bowdlerized form to her personal satisfaction, i.e., deleting any and all, in her own opinion, so-called negative , controversial, provocative or disturbing references to a possible tsunami of transfer-transition troubles, and replace them with more reassuring and positive material***. If I were unwilling to comply with that directive, I could then elect (pun notwithstanding) to conduct my election campaign without the aid of any supporting printed material whatsoever. Failing that course of (in)action, of course the final option would appear to be clearly inevitable (even to one at my advanced age and stage).

Which finally(!) brings me to the complaint which I now must needs draw to your attention : I am of the conviction that Mme Rachel Gravel, in her Federal civii-service employee capacity as Executive Director of Ste. Anne's Hospital, has, as displayed in her above-described conduct toward me, far exceeded the defined and mandated authority, powers and limitations of the official job description of her position and government employee classification or category, and that she should therefore be subject to whatever action s are indicated, in accordance with the applicable CVA prevailing process and protocols,should my contention indeed prove to be upheld.

On the other hand, if it is determined that I am wrong on all counts in my assumptions, and my complaint is wholly unfounded in the ruling /opinion of the VAC Ombudsman, I will unhesitatingly personally apologize and grovel before Gravel, for having wrongfully complained about her a/m actions toward me.

I have here attempted, insofar as possible for me , to present the straight facts, avoiding I.
Pany undue enhancement of the case by injecting my emotional response to what I objectively consider to be an outright and blatant violation of my rights and privileges, as delineated for the treatment of Veterans by VAC employees in the applicable DVA "charter" of yore; let alone as an ordinary Canadian citizen, for whose rights to freedom of speech and of expression many of us once fought so fiercely to protect and preserve.

***I ultimately decided, under both pressure and protest, to "choose door no.1", perforce putting pragmatism before principle and pride, if I might yet have the opportunity to effectively craft beneficial changes from within the existing structure and venue, rather than be limited to punier progress by protest from beyond the pale.

You have my permission to access my VAC file, and I will genuinely appreciate your anticipated response.

Respectfully,

Wolf William Solkin
Ste. Anne's Hospital
Room T-11 / 14
VAC file no. K4730362
tel. (514) 505-3914
<wolf solkin@icloud.com>

Sent from my iPad
~~~

Communication Note Attachment	Attachment File Description
Attachment: Yes	
Created on:	

Summary of Facts

Client Expectation

He would like the civil servant in charge at Sainte-Anne Hospital to be reprimanded and that the scope of her mandate be clarified to her.

Client Perspective

The Veteran submitted the content he wanted printed on a flyer for the election of President of the residents of SAH and was informed in a disrespectful manner by the Director that he either modify and resubmit the content for her approval or risk having no flyer printed to help him in his campaign. The Veteran feels his rights as a citizen and Veteran were violated and that the Director overstepped her mandate.

Departmental Position

After being informed of the Veteran's concernsby the Obudsman. the Deputy Minister has stated he will be following up on the matter and will keep the OVO informed of the outcome.

Assessment
~~~

Intervention Officer

Assessment

Cory Micalef: The Veteran's right to free speech was infringed upon by the Director of SAH as she censured the message on his campaign pamphlet. Deputy Minister is has met with the Ombudsman and will personally look into the matter he said.:

Action Taken

Cory Micalef: Call to the Veteran
Discussed with the OVO Director
Provided information/documents submitted by the Veteran to Senior Mangement for action.

Summary Annex

None

File Closing Information

Success Story: N/A

Findings: Other

Closing Outcome:

File Assignment History

Action	Date	By	File Type	Reason
Assigned To: Cory Micalef	2015-06-17 1:40 PM	Cory Micalef	Complaint	
Assigned To Inventory	2015-05-27 2:21 PM	Daren Dixon	Complaint	

File Summary List

Type	Original Owner	Details
OSR Action Taken	Cory Micalef	Call to the Veteran Discussed issue with Director and the Ombudsman

From: Wolf Solkin <wolfsolkin@icloud.com>
To: Michel Doiron <michel.doiron@vac-acc.gc.ca>
CC: Walter Natynczyk <walter.natynczyk@vac-acc.gc.ca>, <info@ombudsman-veterans.gc.ca>
Date: November 2,2015 11:07
Subject: Fwd: OUTCOME of OFFICIAL COMPLAINT by W. W. SOLKIN TO VAC OMBUDSMAN

[THIS IS TO ACCOMPANY MY LETTER TO MICHEL DOIRON, OF NOVEMBER 2, 2015]

Please provide copy to Mr. Guy Parent.

Sent from my iPad

Begin forwarded message:

> From: Wolf Solkin <wolfsolkin@icloud.com>
> Date: October 2, 2015 at 7:17:29 AM GMT-4
> To: Louise Solkin <louiselanglois.s@gmail.com>
> Subject: OUTCOME of OFFICIAL COMPLAINT by W. W. SOLKIN TO VAC OMBUDSMAN
>
> To all those parties whom this matter may concern:
>
> This statement is being prepared today, October 2nd, 2015, (but held back for distribution until after Oct.9/15), in anticipation of the forthcoming receipt of the official adjudication of my formal complaint, filed on May 27/15, with the Ombudsman of Veterans Affairs Canada, against Mme Rachel Gravel, Executive Director of Ste, Anne's Hospital. Said complaint pertains to certain aspects of Mme Gravel's conduct and actions toward me, which I maintain far exceeded the official mandate/authority of her civiil service position parameters, by suppressing some of my inherent rights as a patient at Ste. Anne's, and also violating my civil rights, as defined in Canada's Charter of Rights and Freedoms (i.e., freedom of thought, belief, opinion and freedom of expression).
>
> The purpose of this memorandum is to go on record, in advance, as to my prediction, assertion and firm conviction that the outcome of the a/m complaint will, as a foregone conclusion, reject the validity and/or justification of my contention(s),plus my request for rectification/vindication, and that, regardless of the true facts of the case, the ruling is pre-ordained to go against me, if for no other reason than that it would hardly do for VAC to suffer embarrassment by rendering a negatively critical statement denigrating "one of their own", particularly in light of her having been recently named (and proudly publicized by VAC) as its recipient of the 2015 "Public Service Employee Award Of Excellence".....presented, no less, by the Governor General at Rideau Hall.
>
> I recognize the sensitivity of the position in which VAC found itself, albeit I am deeply disappointed in how it saw fit to prioritize its components.
>
> Enough said.
>
> Please thank Mr. Michel Doiron for his consideration andi courtesy.
>
> Sincerely,
>
>
> Wolf William Solkin.
>
> Sent from my iPad

From: Wolf Solkin <wolfsolkin@icloud.com>
To: Michel Doiron <michel.doiron@vac-acc.gc.ca>
CC: Walter Natynczyk <walter.natynczyk@vac-acc.gc.ca>, "info@ombudsman-veterans.gc.ca" <info@ombudsman-veterans.gc.ca>
Date: November 2,2015 10:58
Subject: Fwd: OUTCOME of OFFICIAL COMPLAINT by W. W. SOLKIN TO VAC OMBUDSMAN

Dear Mr. Doiron

This in response your official letter to me, of Oct.19,2015, in which you wrote that I need not hesitate to contact you should I "wish to discuss further". By that, I presume you referred to your
ruling against the validity of my complaint that my inherent and proclaimed rights, as a resident/patient at Ste. Anne's Hospital (SAH), and as a Canadian citizen, to freedom of thought, belief, opinion and freedom of expression, were violated by the actions of the SAH Executive Director, (all as outlined in my formal complaint letter to the Veterans Ombudsman dated May 27/15, and elaborated upon at our only meeting, in Aug/15).

From the content and finality of tone in your letter, I do not believe there to be any point to holding anything resembling a "discussion" which might serve any productive purpose, as it is, of course, impossible to quantify, prove or disprove the all too familiar SAH management's ubiquitous "fire wall" mantra/bugaboo about (potential) vague and looming medical/health consequences. I will, however, take advantage of your invitation, to express some of my observations and comments on your decision. When we met, you told me that my letter of complaint had first been jointly considered/discussed by the Ombudsman and the Deputy Minister of Veterans Affairs Canada (VAC), who then called on you to interview me in order to obtain, first hand, a more in-depth view of the situation, following which you were to present your report to them for their study, so that they would be better enabled to render their ruling.

Accordingly, I was nonplussed to realize that not only did you conduct the inquiry, but you also seem to have personally determined the conclusive judgement, and only then did you submit what appears to be an "FYI" copy of same to Mr. Guy Parent (but not, it seems, to General Walter Natynczyk).
Then again, I note, in your cover email to me, you wrote that you were providing me with..."a copy of my (i.e., your) response to the complaint you (i.e., I) had lodged through the Office of the Veterans Ombudsman-file number OMB15-014344. I have copied Mr. Parent on this e-mail, so he is aware and can update his file". Hardly the procedure I was led to expect.

I am also puzzled by the fact that when I asked you if you were a member of the Ombudsman's Office, you hastened to disabuse me of any such impression, clearly stating that, to the contrary, you are the "Associate Deputy Minister for Service Delivery", which role entailed several other/ different functions; And yet, notwithstanding, the final verdict was apparently rendered by you, rather than by an accredited official in the Ombudsman's Office, as I had anticipated by so addressing my initial letter of complaint.

You also wrote that you conducted "a thorough review of the case...and a visit to SAH to gather facts and to interview principle (sic) parties". I am curious as to whether you interviewed the Chief Returning Officer and/or her Deputy, who were directly involved parties. More to the point, were you able find time, during your investigation, to interview a proper statistical sampling of what you termed as "...the greater resident population", within which my " strongly worded (initial flyer) had the potential to cause concern..." ?

It appears to me, from your letter, that you virtually acknowledge, in your words..."that (my) personal rights were infringed...", albeit you seemingly concluded that Mme Rachel Gravel's behaviour toward me, as but one lone individual, was correct and justified in overriding the fundamental fact of my institutional and constitutional rights, on the the sacrificial altar of the greater number, "in support of the hospital's general population".

As an interesting aside, some of your letter's explanatory/justifying words and phrases are readily reminiscent of those with which I have been consistently confronted heretofore by Mme Gravel's traditional "talking points", particularly whenever I protested against the Province's present and/or potential inferior protocols, which she seems so prone to protect from criticism, and which is the predominant cause of my less-than-passive posture, in my efforts to safeguard the future treatment of my fellow-Veterans, as they risk becoming transformed into Provincial ciphers.

Your letter expressed your "...trust (that your decision) brings this matter to a close...". I must confess it is difficult for me to concur with you at this time, as I continue to have lingering doubts, not only about the validity of your conclusion , but also the process and personnel engaged in its formation.

I might well be considered Quixotic in my tilting at the windmills of government bureaucracy and its circle-the-wagons reflexive tactics, but then again, not all windmills are inevitably indestructible, nor inexorably impregnable against the arsenal of public protestation, in defence of one's prized principles and sacrosanct rights.

Regardless of your declared decision /opinion, I am not only a proud Canadian Veteran now living out my life at Ste. Anne's Hospital, under its Charter of Resident's Rights and Responsibilities, but, perhaps of even greater import, is that I am also a proud Canadian Citizen, now living out my life in the country for which I had once voluntarily fought, under the Canadian Charter of Rights and Freedoms, which is above individual, subjective interpretation and dismissal, let alone rescindment..

As Mr. Guy Parent himself recently and openly urged us Veterans..."Go for it, and continue to free the facts"!
Sounds like a sound idea !

In conclusion, and by way of demonstrating /verifying that today's email is not a matter of post-facto "sour gripes", I am also sending you, under separate cover, copy of an earlier email I had composed for the attention of the VAC Ombudsman Office , and which I sent to my wife

From: Guy Parent
To: Cory Micalef; Michel Doiron
Date: 2015/10/21 8:49 AM
Subject: Re: MY FORMAL COMPLAINT TO THE OMBUDSMAN

Merci Michel,
J`espère qu`il sera satisfait.
Guy

Guy Parent
Veterans Ombudsman | Ombudsman des vétérans
Office of the Veterans Ombudsman | Bureau de l'ombudsman des vétérans
Ottawa, Canada
Guy.Parent@ombudsman-veterans.gc.ca
Telephone | Téléphone: 613-944-2950
Facsimile | Télécopieur:613-944-2939
www.ombudsman-veterans.gc.ca
Government of Canada | Gouvernement du Canada
>>> Michel Doiron 2015/10/19 3:11 PM >>>
Mr. Solkin,
Again, please accept my deepest regrets for this delay. Attached please find a copy of my response to the complaint you had lodged through the Office of the Veterans Ombudsman - file number OMB15-014344. I have copied Mr. Parent on this e-mail, so he is aware and can update his file.

I truly hope this information brings the matter to a close for you but please do not hesitate to contact me should you wish to discuss further.

Sincerely, Michel

Michel D. Doiron
Assistant Deputy Minister, Service Delivery Branch / SMA, Secteur de la prestation des services
Veterans Affairs Canada / Anciens Combattants Canada
P.O. Box 7700 / C.P. 7700
Charlottetown, PE C1A 8M9 / Charlottetown, Î.-P.-É. C1A 8M9
Telephone / Téléphone (902) 626-2723 / michel.doiron@vac-acc.gc.ca / Facsimile / Télécopieur (902) 566-8172
Government of Canada / Gouvernement du Canada
http://www.veterans.gc.ca/

>>> Michel Doiron 2015/10/16 11:41 AM >>>
Mr. Solkin,

Please accept my sincere apologies for the delay. I have been out of the office on sick leave, but will provide you with a formal response on Monday.

Michel

Michel D. Doiron
Assistant Deputy Minister, Service Delivery Branch / SMA, Secteur de la prestation des services
Veterans Affairs Canada / Anciens Combattants Canada
P.O. Box 7700 / C.P. 7700
Charlottetown, PE C1A 8M9 / Charlottetown, Î.-P.-É. C1A 8M9
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http://www.veterans.gc.ca/

>>> Wolf Solkin <wolfsolkin@icloud.com> 2015/10/16 9:52 AM >>>
Good morning, Mr. Doiron...
Today marks one week to the day, that your last email to me (Sept.30/15) led me, as you wrote, to "expect to have the response (to my formal complaint of May 27/15) ready and sent by Friday, Oct. 9, 2015". I therefore feel I am not being unduly forward in requesting that you now please inform me as to the precise present status of that response, and when I can truly expect to have the final document in my possession.

Veterans Affairs Canada | Anciens Combattants Canada

Assistant Deputy Minister Service Delivery | Sous-ministre adjoint Prestation des services

PO Box 7700 Charlottetown PE C1A 8M9 | CP 7700 Charlottetown (Î.-P.-É) C1A 8M9

OCT 1 9 2015

Mr. Wolf Solkin
305 des Anciens-Combattants
Room T-11 / 14, Ste. Anne's Hospital
Montreal, QC H9X 1Y9

Dear Mr. Solkin,

This is in response to the complaint you raised to the Office of the Veterans Ombudsman regarding the Sainte Anne's Hospital (SAH) Resident's Committee Election Process. Thank you for allowing me the time needed for a thorough review of the case.

My investigation included a document review and a visit to SAH to gather facts and to interview principle parties.

Upon review and consideration of all facts and statements, I do not believe that the hospital leadership acted improperly. The information contained in your initial flyer was strongly worded and had the potential to cause concern within the greater resident population, many of whom have vulnerable health or mental conditions. The leadership of the hospital acted for the welfare of the entire resident population, which I believe was the correct action.

I carefully read the Residents' Rights and Responsibility charter, and although you raised good points specifically with regards to section A-12, I believe the document also supports the actions from SAH leadership, specifically as it relates to providing an environment that affords peace of mind to all residents.

Mr. Solkin, I find that the hospital acted in good faith, within acceptable practice and level of authority. I know that you feel that your personal rights were infringed; however, the actions taken were in support of the hospital's general population and therefore, were appropriate.

I close by taking the opportunity to personally thank you for your dedicated services to this great country. I also thank you for taking the time to meet with me and to provide detailed required. I trust this information brings this matter to a close, but please don't hesitate to contact me should you wish to discuss further.

Respectfully,

Michel Doiron

cc: Guy Parent, Veterans Ombudsman

Canada

From: Wolf Solkin <wolfsolkin@icloud.com>
To: "info@ombudsman-veterans.gc.ca" <info@ombudsman-veterans.gc.ca>
Date: July 23,2015 17:47
Subject: Two follow-up emails to Letter of Complaint

Hello, Mr. Micalef...
I am sending this simply to inquire whether you received (in good/legible condition) the two emails I sent to you on July 22/15, as my iPad has been misbehaving lately.

One email contained text plus an attachment, and the other had text only.

Do please reply and let me know whether I should re-send one or both items., as had been verbally requested by you.

Respectfully,

Wolf William Solkin.

Sent from my iPad

Bachelor of Arts, McGill University, Master of Social Work, University of Toronto – Served as Editor in Chief of "The Veterans' Voice", and Director of the Residents' Committee – Served in combat as Lieutenant with The Algonquin Regiment in Holland and Germany, until V-E Day and beyond – Respectfully asking for your vote to elect me as President, so I can continue in your service, especially during the difficult transfer/transition times ahead.

William Wolf Solkin, 11th floor

We now enjoy "the good life": excellent health care, experienced employees, entertainments, etc., and I am determined to fight to maintain our present level of care and standard of living, and fulfil all responsibilities of the President.

BUT, we are now on the verge of major changes, and we'll soon be transferred to Quebec's Department of Health and Social Services, with its different protocols of care, and services with implications for our present way of life.

I live in hope that the assurances by Veterans Affairs Canada that our standards of care will not be diminished and their promises to us will be faithfully upheld by all parties, once Quebec gains control. Were that, unfortunately, not to turn out as anticipated, in spite of our efforts at cooperation, we would then need to speak up loud and clear for ourselves and our staff, through your Residents' Committee under my focused leadership, in treating jointly with Management, Veterans Affairs Canada, and the Transition Committee with its Quebec members. For the next two to three years of the transition, we are going to be ever-vigilant to preserve our way of life and protect what is rightly ours. That objective is what I am committed to undertake for my comrades, with a revitalized Residents' Committee, under my leadership as President, thanks to your support in electing me to spearhead all our efforts on your behalf. Your vote for me will be very much appreciated. "LEAVE NO VET BEHIND!"

Wolf William Solkin (I may have lost all my teeth, but I've still got all my marbles!)

From: Wolf Solkin <wolfsolkin@icloud.com>
To: "info@ombudsman-veterans.gc.ca" <info@ombudsman-veterans.gc.ca>
Date: July 23,2015 08:13
Subject: Attention Mr. Cory Micalef........re Complaint to Ombudsman. PLS.NOTE:I'M RESENDING THIS , IN CASE YESTERDAY's EMAIL ARRIVED SKEWED.
Attachments: IMG_0772.JPG; Part.002

Dear Sir...below is a reproduction of the final "approved " (by Mme Rachel Gravel) version of the "Election Notice"/Flyer which I was eventually permitted to use in the recent election for President of the Ste. Anne's Hospital Residents'Committee (except for typo reversal of my given names).

This will be followed by a second email containing a copy of the previous /original version, which Mme Gravel had refused to allow under any circumstances, which action I deem to have been unwarranted and, more important,an unauthorized and unlawful violation of my rights as a Resident-Veteran at Ste. Anne's, let alone as a Canadian citizen,in addition to being far in excess of her mandated civil service position at Veterans Affairs Canada.

If there is any problem in your receipt of this and/or the succeeding email, please advise.

Many thanks for your prompt attention to this complaint.

Respectfully,

Wolf William Solkin.

From: Wolf Solkin <wolfsolkin@icloud.com>
To: "info@ombudsman-veterans.gc.ca" <info@ombudsman-veterans.gc.ca>
Date: July 22,2015 17:15
Subject: Fwd: WW SOLKIN TEXT FOR ELECTION NOTICE (English).....under 300 words; if not, PLS.ADVISE !

Attention Mr. Cory Micalef,...below is the (much bowdlerized and abridged) original version of the Election Notice/Flyer which I submitted to the Secretary of the Election Committee for printing and distribution, but which was adamantly and arbitrarily rejected by Mme Rachel Gravel , all as outlined to you in my initial complaint letter, largely due to my own personal comments, concerns and misgivings regarding the effects upon Ste. Anne's Hospital and its Resident-Veterans, of the forthcoming transfer from Federal to (Quebec) Provincial jurisdiction, which I felt it necessary and important to share with my comrades.

Mme Gravel told me, among other things, that she objected to my negative/disrespectful/deprecating statements about the standards and protocols of Quebec's Health Department., albeit that was the principal purpose and thrust of my thesis.

Do please let me know if I can be of any further assistance in this, to me, so vital an issue that I am prepared to risk possible reprisals /consequences for having initiated this complaint.

Respectfully,

Wolf William Solkin.

Sent from my iPad

Begin forwarded message:

> Subject: Fwd: WW SOLKIN TEXT FOR ELECTION NOTICE (English).....under 300 words; if not, PLS.ADVISE !
>
>
>
> Sent from my iPad
>
> Begin forwarded message:
>
>> From: Wolf Solkin <wolfsolkin@icloud.com>
>> Date: May 14, 2015 at 11:17:56 AM GMT-4
>> To: Nancy Latour <Nancy.Latour@vac-acc.gc.ca>
>> Subject: WW SOLKIN TEXT FOR ELECTION NOTICE (English).....under 300 words; if not, PLS.ADVISE !
>>
>> WOLF WILLIAM SOLKIN: Served as Editor in Chief of "the Veterans' Voice", and Director of the Residents' Committee. Respectfully asking for your vote to elect me as President, so I can continue in your service, especially during the difficult transfer/transition times ahead.
>>
>> #Served in combat as Lieutenant with The Algonquin Regiment in Holland and Germany, until V-E Day and beyond.
>>
>> #Bachelor of Arts, McGill University; Master of Social Work, University of Toronto.
>>
>> We now enjoy"the good life": excellent health care, experienced employees, entertainments, etc., and I am determined to fight to maintain our present level of care and standard of living, and fulfil all other mandated responsibilities of the President.
>>
>> BUT, we are now on the precipice of a very steep cliff, and we'll soon be pushed over into the pit of Quebec's Department of Health, with its poorer protocols of care, staff and services,waiting to infiltrate our lines and our lives.
>>
>> I am convinced, in spite of assurances by Veterans Affairs Canada (VAC) that our standards of care will not be diminished, that once Quebec gains control they will shaft us, unless we take our heads out of the sand of silence, and speak up for ourselves, loud and clear, to the politicians and the public...and it will be my duty to "take the point"!
>>
>> For the next two to three years of the transition, we are going to have one helluva fight on our hands to preserve our way of life and protect what is rightly ours, against our new masters. That very fight is precisely what I am committed to undertake for my SAH comrades, in cooperative harness with a revitalized Residents' Committee, with my leadership as its President.
>>
>>
>>
>> YOUR VOTE WILL BE MUCH APPRECIATED
>>
>> WOLF WILLIAM SOLKIN
>>
>>
>> Sent from my iPad

Candidate – 2015 elections Residents' Committee

William Wolf Solkin, 11th floor

Bachelor of Arts, McGill University; Master of Social Work, University of Toronto - Served as Editor in Chief of "The Veterans' Voice", and Director of the Residents' Committee - Served in combat as Lieutenant with The Algonquin Regiment in Holland and Germany, until V-E Day and beyond - Respectfully asking for your vote to elect me as President, so I can continue in your service, especially during the difficult transfer/transition times ahead.

We now enjoy "the good life": excellent health care, experienced employees, entertainments, etc., and I am determined to fight to maintain our present level of care and standard of living, and fulfil all responsibilities of the President.

BUT, we are now on the verge of major changes, and we'll soon be transferred to Quebec's Department of Health and Social Services, with its different protocols of care, and services with implications for our present way of life.

I live in hope that the assurances by Veterans Affairs Canada that our standards of care will not be diminished and their promises to us will be faithfully upheld by all parties, once Quebec gains control. Were that, unfortunately, not to turn out as anticipated, in spite of our efforts at cooperation, we would then need to speak up loud and clear for ourselves and our staff, through your Residents' Committee under my focused leadership, in treating jointly with Management, Veterans Affairs Canada, and the Transition Committee with its Quebec members. For the next two to three years of the transition, we are going to be ever-vigilant to preserve our way of life and protect what is rightly ours. That objective is what I am committed to undertake for my comrades, with a revitalized Residents' Committee, under my leadership as President, thanks to your support in electing me to spearhead all our efforts on your behalf. Your vote for me will be very much appreciated. "LEAVE NO VET BEHIND!"

Wolf William Solkin (I may have lost all my teeth, but I've still got all my marbles!)

From: Guy Parent
To: Cory Micalef; Guay, Michel
CC: Lilsa Blagden; Sharon Squire
Date: 2015/07/29 9:42 AM
Subject: Mr S. SAH case

Hi Michel,
Documents concerning the above case were hand delivered by myself to Deputy Minister Veterans Affairs Canada yesterday afternoon. The DM accepted the case and indicated that he will be taking action, and that we will be informed of the outcomes.
Cory, could you please enter a note to that effect in the file.
thanks
Guy

Guy Parent
Veterans Ombudsman | Ombudsman des vétérans
Office of the Veterans Ombudsman | Bureau de l'ombudsman des vétérans
Ottawa, Canada
Guy.Parent@ombudsman-veterans.gc.ca
Telephone | Téléphone: 613-944-2950
Facsimile | Télécopieur:613-944-2939
www.ombudsman-veterans.gc.ca
Government of Canada | Gouvernement du Canada

Bachelor of Arts [illegible] Master of Social Work [illegible] Toronto. Served as [illegible] "The Veterans' Voice" [illegible] the Residents' Committee. [illegible] combat as Lieutenant with The Algonquin Regiment in Holland and Germany, until V-E Day and beyond. Respectfully asking for your vote to elect me as President, so I can continue in your service, especially during the difficult transfer/transition times ahead.

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"LEAVE NO VET BEHIND!"

Wolf William Solkin (I may have lost all my teeth, but I've still got all my marbles!)

Case Information

File Number: OMB15-014344

Received: ********* by DJDI		**Type:** Intervention	
Assigned: 17-JUN-15 to CXMI		**File is:** **Open**	
Priority: Normal	**Contact:** Email	**Status:** File Created	
Region: Quebec	**Category/Program:** VAC Services & Benefits -_Other -Canada Remembers		

Issues:

Issue:	Feels that the current Executive Director of Ste. Annes Hospital, Mme Rachel Gravel, has overstepped her mandate and authority as a pulic servant.
Issue Type:	BOR
Issue Status:	Active

Stakeholder:

Mr. Wolf Solkin 305 des Anciens-Combattants Room T-11 / 14 Ste. Anne's Hospital Montreal, QC H9X 1Y9		**VAC #:**	4730362
		Organization:	
		Title:	
Home ph:	(514) 505-3914	**Work:**	
Cell:		**Fax:**	
Additional Info.:			

Intake Note:

Email from Mr. Solkin follows:

~~~~

I am a WW II Veteran, now in "permanent" residence at Ste. Anne's Hospital . I was a member/director of the soon-to-be outgoing Residents' Committee , plus having been the creator, writer and Editor-in-Chief of "The Veterans' Voice", an innovative , in-house newsletter dedicated to the cause and concerns of the Veteran population quartered at Ste. Anne's.

I am now a candidate for the office of president of the SAH Residents' Committee. The election date is set for May 29/15, and therefore I wish to go on record with my complaint before that date, "win, lose, or draw", so that it may not be misconstrued as a matter of " sour gripes ", should the end result not be in my favour. While reluctant to bring this issue to the fore before now, I have finally permitted principle to prevail over politesse.

After my nomination document was properly submitted, I received a call requesting that I meet with the official volunteer (Mme Mychele Amberg) selected as "Election Returning Officer". Also present were Mme Nancy Latour, a staff member designated to be "Deputy Returning Officer"/Secretary, and Mme Joanne Grondin, another staff member, who had been appointed by "Management", as a (rotational) temporary Ombudsman, in situ.
~~~~

Case Information

File Number: OMB15-014344

Intake Note:

The purpose of that meeting was to present me with a typed document, signed by the Returning Officer and her Deputy, which was titled as follows:
"2015-2018 Elections - Residents' Committee
Information on the election/campaign process for presidential candidates".

The contents of the a/m document was, in essence, a short set of fairly straightforward rules and regulations governing such items as: conduct of the election process; permitted size of written campaign/election notices; date and place(s) of voting; and the like. Those stipulations and conditions were then discussed on an item-by-item basis, and subsequently accepted .

At no time did the document itself, nor any of part of the discussion related to it, make any reference whatsoever to restrictions of any kind or nature pertaining to the subject matter/ content, wording, writing style , tone. etc., of the "text" of the permitted "election notice" (i.e., campaign flyer). The only stated submission requirements were/are that it be " ... a bilingual text with a maximum of 300 words written by the candidate to be submitted to the election secretary no later than May 15, 2015 (and)...can be printed in format 8.5 x 11...so that candidates can distribute them...".

Shortly after having submitted the text of my election notice/flyer in full accordance with all the declared conditions quoted and/or referred to above, I was summarily summoned to the office of Mme Rachel Gravel, the current Executive Director of Sre. Anne's Hospital, who informed me, in no uncertain terms, that under no circumstances would she ever allow my election notice, as originally conceived and duly submitted by me, to be printed by her Communications and Commemoration Directorate, let alone be posted and/or circulated anywhere in (her) hospital !

[Note that the main theme of my thesis was the impending injurious effects upon Ste. Anne's Hospital and its vulnerable Veterans, of the upcoming transfer from Federal to Provincial/Quebec command and control].

I admit to having been more than merely taken aback by what I deemed to be such an egregiously unilateral and autocratic decision (which I believe/d to be both unwarranted and unlawful). When I asked to know the reasons for her unyielding draconian stance, Mme Gravel told me (and I both paraphrase and quote, to the best of my nonagenarian capacity for recall), that she personally considered the wording and tone of my text to be entirely too improper and unacceptably confrontational, aggressive , and denigrating toward The Province of Quebec and its Health Department. Nor was I to make reference to what are (in my opinion and that of others) the lower standards of care, poorer staff-to-patient ratios, and less professionally effective protocols under the aegis of Quebec, than are to be found within our current Federal governance.

Mme Gravel's other major objection was that she was convinced my envisioning and portraying future damoclean problems and concerns affecting my fellow-resident/patients, which disruptive difficulties I am confident will be spawned by the forthcoming transfer/transition of Ste, Anne's Hospital from Federal to (Quebec's) Provincial jurisdiction, would only serve to make our Residents and their families anxious and disquieted about their future fate. It should, perhaps be noted here that my views are, coincidentally,

Case Information

File Number: OMB15-014344

Intake Note:

diametrically opposed to the position manifested in a recent letter from Mme Gravel to all patients' families, expressing her open optimism, coupled with her emphatic assurances of a virtually seamless transition, which would patently redound to the benefit of all souls involved, and so the transfer need not be feared as a threat to anyone, all as personally vouchsafed by her.

When I inquired as to what were my options , Mme Gravel unhesitatingly and firmly replied that I could agree to re-write my election notice/flyer in bowdlerized form to her personal satisfaction, i.e., deleting any and all, in her own opinion, so-called negative , controversial, provocative or disturbing references to a possible tsunami of transfer-transition troubles, and replace them with more reassuring and positive material***. If I were unwilling to comply with that directive, I could then elect (pun notwithstanding) to conduct my election campaign without the aid of any supporting printed material whatsoever. Failing that course of (in)action, of course the final option would appear to be clearly inevitable (even to one at my advanced age and stage).

Which finally(!) brings me to the complaint which I now must needs draw to your attention : I am of the conviction that Mme Rachel Gravel, in her Federal civii-service employee capacity as Executive Director of Ste. Anne's Hospital, has, as displayed in her above-described conduct toward me, far exceeded the defined and mandated authority, powers and limitations of the official job description of her position and government employee classification or category, and that she should therefore be subject to whatever action s are indicated, in accordance with the applicable CVA prevailing process and protocols,should my contention indeed prove to be upheld.

On the other hand, if it is determined that I am wrong on all counts in my assumptions, and my complaint is wholly unfounded in the ruling /opinion of the VAC Ombudsman, I will unhesitatingly personally apologize and grovel before Gravel, for having wrongfully complained about her a/m actions toward me.

I have here attempted, insofar as possible for me , to present the straight facts, avoiding l.
Pany undue enhancement of the case by injecting my emotional response to what I objectively consider to be an outright and blatant violation of my rights and privileges, as delineated for the treatment of Veterans by VAC employees in the applicable DVA "charter" of yore; let alone as an ordinary Canadian citizen, for whose rights to freedom of speech and of expression many of us once fought so fiercely to protect and preserve.

***I ultimately decided, under both pressure and protest, to "choose door no.1", perforce putting pragmatism before principle and pride, if I might yet have the opportunity to effectively craft beneficial changes from withi the existing structure and venue, rather than be limited to punier progress by protest from beyond the pale.

You have my permission to access my VAC file, and I will genuinely appreciate your anticipated response.

Respectfully,

Wolf William Solkin
Ste. Anne's Hospital

Case Information

File Number: OMB15-014344

Intake Note:

Room T-11 / 14
VAC file no. K4730362
tel. (514) 505-3914
<wolf solkin@icloud.com>

Sent from my iPad

From:	Wolf Solkin <wolfsolkin@icloud.com>
To:	<info@ombudsman-veterans.gc.ca>
Date:	July 22,2015 16:26
Subject:	Attention Mr. Cory Micalef........re Complaint to Ombudsman.
Attachments:	IMG_0772.JPG; Part.002

Dear Sir...below is a reproduction of the final "approved " (by Mme Rachel Gravel) version of the "Election Notice"/Flyer which I was eventually permitted to use in the recent election for President of the Ste. Anne's Hospital Residents'Committee (except for typo reversal of my given names).

This will be followed by a second email containing a copy of the previous /original version, which Mme Gravel had refused to allow under any circumstances, which action I deem to have been unwarranted and, more important,an unauthorized and unlawful violation of my rights as a Resident-Veteran at Ste. Anne's, let alone as a Canadian citizen,in addition to being far in excess of her mandated civil service position at Veterans Affairs Canada.

If there is any problem in your receipt of this and/or the succeeding email, please advise.

Many thanks for your prompt attention to this complaint.

Respectfully,

Wolf William Solkin.

From: Cory Micalef
To: Guay, Michel; Parent, Guy; Squire, Sharon
Date: 2015/07/23 10:28 AM
Subject: Wolf Solkin Complaint
Attachments: Solkin flyer content.pdf; Solkin Letter of Complaint.pdf

Good morning,

Herewith attached is the information we requested from the Veteran as well as the complaint submitted to the OVO.

Solkin Flyer
Page 1 : Email to me

End of page 1 and 2: The initial content he submitted by email to be printed on the flyer that was subsequently not permitted.

Page 3 : The final flyer

Solkin Letter
The complaint letter sent to the OVO.

If you need additional information please let me know.

From: Wolf Solkin <wolfsolkin@icloud.com>
To: "info@ombudsman-veterans.gc.ca" <info@ombudsman-veterans.gc.ca>
Date: May 27,2015 11:24
Subject: Complaint by/ from Wolf William Solkin (file No. K 4730362)...to VAC Ombudsman CORRECTION...12th para.,VAC vs CVA

I am a WW II Veteran, now in "permanent" residence at Ste. Anne's Hospital . I was a member/director of the soon-to-be outgoing Residents' Committee , plus having been the creator, writer and Editor-in-Chief of "The Veterans' Voice", an innovative , in-house newsletter dedicated to the cause and concerns of the Veteran population quartered at Ste. Anne's.

I am now a candidate for the office of president of the SAH Residents' Committee. The election date is set for May 29/15, and therefore I wish to go on record with my complaint before that date, "win, lose, or draw", so that it may not be misconstrued as a matter of " sour gripes ", should the end result not be in my favour. While reluctant to bring this issue to the fore before now, I have finally permitted principle to prevail over politesse.

After my nomination document was properly submitted, I received a call requesting that I meet with the official volunteer (Mme Mychele Amberg) selected as "Election Returning Officer". Also present were Mme Nancy Latour, a staff member designated to be "Deputy Returning Officer"/Secretary, and Mme Joanne Grondin, another staff member, who had been appointed by "Management", as a (rotational) temporary Ombudsman, in situ.

The purpose of that meeting was to present me with a typed document, signed by the Returning Officer and her Deputy, which was titled as follows:
"2015-2018 Elections - Residents' Committee
Information on the election/campaign process for presidential candidates".

The contents of the a/m document was, in essence, a short set of fairly straightforward rules and regulations governing such items as: conduct of the election process; permitted size of written campaign/election notices; date and place(s) of voting; and the like. Those stipulations and conditions were then discussed on an item-by-item basis, and subsequently accepted .

At no time did the document itself, nor any of part of the discussion related to it, make any reference whatsoever to restrictions of any kind or nature pertaining to the subject matter/ content, wording, writing style , tone. etc., of the "text" of the permitted "election notice" (i.e., campaign flyer). The only stated submission requirements were/are that it be " ... a bilingual text with a maximum of 300 words written by the candidate to be submitted to the election secretary no later than May 15, 2015 (and)...can be printed in format 8.5 x 11...so that candidates can distribute them...".

Shortly after having submitted the text of my election notice/flyer in full accordance with all the declared conditions quoted and/or referred to above, I was summarily summoned to the office of Mme Rachel Gravel, the current Executive Director of Ste. Anne's Hospital, who informed me, in no uncertain terms, that under no circumstances would she ever allow my election notice, as originally conceived and duly submitted by me, to be printed by her Communications and Commemoration Directorate, let alone be posted and/or circulated anywhere in (her) hospital !

[Note that the main theme of my thesis was the impending injurious effects upon Ste. Anne's Hospital and its vulnerable Veterans, of the upcoming transfer from Federal to Provincial/Quebec command and control].

I admit to having been more than merely taken aback by what I deemed to be such an egregiously unilateral and autocratic decision (which I believe/d to be both unwarranted and unlawful). When I asked to know the reasons for her unyielding draconian stance, Mme Gravel told me (and I both paraphrase and quote, to the best of my nonagenarian capacity for recall), that she personally considered the wording and tone of my text to be entirely too improper and unacceptably confrontational, aggressive , and denigrating toward The Province of Quebec and its Health Department. Nor was I to make reference to what are (in my opinion and that of others) the lower standards of care, poorer staff-to-patient ratios, and less professionally effective protocols under the aegis of Quebec, than are to be found within our current Federal governance.

Mme Gravel's other major objection was that she was convinced my envisioning and portraying future damoclean problems and concerns affecting my fellow-resident/patients, which disruptive difficulties I am confident will be spawned by the forthcoming transfer/transition of Ste, Anne's Hospital from Federal to (Quebec's) Provincial jurisdiction, would only serve to make our Residents and their families anxious and disquieted about their future fate. It should, perhaps be noted here that my views are, coincidentally, diametrically opposed to the position manifested in a recent letter from Mme Gravel to all patients' families, expressing her open optimism, coupled with her emphatic assurances of a virtually seamless transition, which would patently redound to the benefit of all souls involved, and so the transfer need not be feared as a threat to anyone, all as personally vouchsafed by her.

When I inquired as to what were my options , Mme Gravel unhesitatingly and firmly replied that I could agree to re-write my election notice/flyer in bowdlerized form to her personal satisfaction, i.e., deleting any and all, in her own opinion, so-called negative , controversial, provocative or disturbing references to a possible tsunami of transfer-transition troubles, and replace them with more reassuring and positive material***. If I were unwilling to comply with that directive, I could then elect (pun notwithstanding) to conduct my election campaign without the aid of any supporting printed material whatsoever. Failing that course of (in)action, of course the final option would appear to be clearly inevitable (even to one at my advanced age and stage).

Which finally(!) brings me to the complaint which I now must needs draw to your attention : I am of the conviction that Mme Rachel Gravel, in her Federal civil-service employee capacity as Executive Director of Ste. Anne's Hospital, has, as displayed in her above-described conduct toward me, far exceeded the defined and mandated authority, powers and limitations of the official job description of her position and government employee classification or category, and that she should therefore be subject to whatever action s are indicated, in accordance with

the applicable CVA prevailing process and protocols,should my contention indeed prove to be upheld.

On the other hand, if it is determined that I am wrong on all counts in my assumptions, and my complaint is wholly unfounded in the ruling /opinion of the VAC Ombudsman, I will unhesitatingly personally apologize and grovel before Gravel, for having wrongfully complained about her a/m actions toward me.

I have here attempted, insofar as possible for me , to present the straight facts, avoiding l.
Pany undue enhancement of the case by injecting my emotional response to what I objectively consider to be an outright and blatant violation of my rights and privileges, as delineated for the treatment of Veterans by VAC employees in the applicable DVA "charter" of yore; let alone as an ordinary Canadian citizen, for whose rights to freedom of speech and of expression many of us once fought so fiercely to protect and preserve.

***I ultimately decided, under both pressure and protest, to "choose door no.1", perforce putting pragmatism before principle and pride, if I might yet have the opportunity to effectively craft beneficial changes from within the existing structure and venue, rather than be limited to punier progress by protest from beyond the pale.

You have my permission to access my VAC file, and I will genuinely appreciate your anticipated response.

Respectfully,

Wolf William Solkin
Ste. Anne's Hospital
Room T-11 / 14
VAC file no. K4730362
tel. (514) 505-3914
<wolf solkin@icloud.com>

Sent from my iPad

From: Wolf Solkin <wolfsolkin@icloud.com>
To: "info@ombudsman-veterans.gc.ca" <info@ombudsman-veterans.gc.ca>
Date: July 22,2015 17:15
Subject: Fwd: WW SOLKIN TEXT FOR ELECTION NOTICE (English).....under 300 words; if not, PLS.ADVISE !

Attention Mr. Cory Micalef....below is the (much bowdlerized and abridged) original version of the Election Notice/Flyer which I submitted to the Secretary of the Election Committee for printing and distribution, but which was adamantly and arbitrarily rejected by Mme Rachel Gravel , all as outlined to you in my initial complaint letter, largely due to my own personal comments, concerns and misgivings regarding the effects upon Ste. Anne's Hospital and its Resident-Veterans, of the forthcoming transfer from Federal to (Quebec) Provincial jurisdiction, which I felt it necessary and important to share with my comrades.

Mme Gravel told me, among other things, that she objected to my negative/disrespectful/deprecating statements about the standards and protocols of Quebec's Health Department., albeit that was the principal purpose and thrust of my thesis.

Do please let me know if I can be of any further assistance in this, to me, so vital an issue that I am prepared to risk possible reprisals /consequences for having initiated this complaint.

Respectfully,

Wolf William Solkin.

Sent from my iPad

Begin forwarded message:

> Subject: Fwd: WW SOLKIN TEXT FOR ELECTION NOTICE (English).....under 300 words; if not, PLS.ADVISE !
>
>
>
> Sent from my iPad
>
> Begin forwarded message:
>
>> From: Wolf Solkin <wolfsolkin@icloud.com>
>> Date: May 14, 2015 at 11:17:56 AM GMT-4
>> To: Nancy Latour <Nancy.Latour@vac-acc.gc.ca>
>> Subject: WW SOLKIN TEXT FOR ELECTION NOTICE (English).....under 300 words; if not, PLS.ADVISE !
>>
>> WOLF WILLIAM SOLKIN: Served as Editor in Chief of "the Veterans' Voice", and Director of the Residents' Committee. Respectfully asking for your vote to elect me as President, so I can continue in your service, especially during the difficult transfer/transition times ahead.
>>
>> #Served in combat as Lieutenant with The Algonquin Regiment in Holland and Germany, until V-E Day and beyond.
>>
>> #Bachelor of Arts, McGill University; Master of Social Work, University of Toronto.
>>
>> We now enjoy"the good life": excellent health care, experienced employees, entertainments, etc., and I am determined to fight to maintain our present level of care and standard of living, and fulfil all other mandated responsibilities of the President.
>>
>> BUT, we are now on the precipice of a very steep cliff, and we'll soon be pushed over into the pit of Quebec's Department of Health, with its poorer protocols of care, staff and services,waiting to infiltrate our lines and our lives.
>>
>> I am convinced, in spite of assurances by Veterans Affairs Canada (VAC) that our standards of care will not be diminished, that once Quebec gains control they will shaft us, unless we take our heads out of the sand of silence, and speak up for ourselves, loud and clear, to the politicians and the public...and it will be my duty to "take the point"!
>>
>> For the next two to three years of the transition, we are going to have one helluva fight on our hands to preserve our way of life and protect what is rightly ours, against our new masters. That very fight is precisely what I am committed to undertake for my SAH comrades, in cooperative harness with a revitalized Residents' Committee, with my leadership as its President.
>>
>>
>>
>> YOUR VOTE WILL BE MUCH APPRECIATED
>>
>> WOLF WILLIAM SOLKIN
>>
>>
>> Sent from my iPad

Office of the Veterans Ombudsman

File Number: OMB-14344 **PROTECTED B**

Contact and File Information

Contact Information

Pref. Salutation:	Mr.	**VAC Client #:**	4730362
Full Name:	Wolf Solkin	**Service #:**	
Date of Birth:	1923/5/1	**Service Category:**	Traditional Veteran
Sex:	M		
Address:	305 des Anciens-Combattants Room T-11 / 14 Montreal-, Quebec H9X1Y9	**Consent to survey:**	
		Townhall Notification:	Not asked
Pref. Language:	English	**How did you hear about us:**	OVO website
Method of Contact:	Any		
Email:	wolfsolkin@icloud.com	**Modified On:**	2018/5/1
Primary Phone #:	(514) 505-3914	**Modified By:**	Lorne Allaire
Secondary Phone #:		**Stakeholder Risks:**	No
Contact Notes:			

File Information

Active/Closed:	File Closed	**Action Required:**	
File Type:	Complaint		
Priority:	Normal	**QA'd:**	No
Consent Provided:	Provided	**QA'd By:**	
Origin:	Email		
Recieved Date	2015/5/27	**Web Ref #:**	
Created On:	2015/5/27	**Physical File:**	
Created By:	Lorne Allaire		
Assigned Date:	2015/5/27		
Closed Date:	2015/9/9		

File Detail

Intake Note

Email from Mr. Solkin follows:

~~~~

I am a WW II Veteran, now in "permanent" residence at Ste. Anne's Hospital . I was a member/director of the soon-to-
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be outgoing Residents' Committee , plus having been the creator, writer and Editor-in-Chief of "The Veterans' Voice", an innovative , in-house newsletter dedicated to the cause and concerns of the Veteran population quartered at Ste. Anne's.

I am now a candidate for the office of president of the SAH Residents' Committee. The election date is set for May 29/15, and therefore I wish to go on record with my complaint before that date, "win, lose, or draw", so that it may not be misconstrued as a matter of " sour gripes ", should the end result not be in my favour. While reluctant to bring this issue to the fore before now, I have finally permitted principle to prevail over politesse.

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Information on the election/campaign process for presidential candidates".

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Pany undue enhancement of the case by injecting my emotional response to what I objectively consider to be an outright and blatant violation of my rights and privileges, as delineated for the treatment of Veterans by VAC employees in the applicable DVA "charter" of yore; let alone as an ordinary Canadian citizen, for whose rights to freedom of speech and of expression many of us once fought so fiercely to protect and preserve.

***I ultimately decided, under both pressure and protest, to "choose door no.1", perforce putting pragmatism before principle and pride, if I might yet have the opportunity to effectively craft beneficial changes from within the existing structure and venue, rather than be limited to punier progress by protest from beyond the pale.

You have my permission to access my VAC file, and I will genuinely appreciate your anticipated response.

Respectfully,

Wolf William Solkin
Ste. Anne's Hospital
Room T-11 / 14
VAC file no. K4730362
tel. (514) 505-3914
<wolf solkin@icloud.com>

Sent from my iPad
~~~~

Issue

Executive Director of Ste. Annes Hospital overstepped her mandate and authority as a pulic servant.

Category/Program: Canada Remembers **Issue Type:** Bill of Rights

Communication Notes
~~~~

Office of the Veterans Ombudsman

Date communication occurred: 2015-11-09 4:19 PM	**Communication Contact Data**
Communication method: Email	**First name:** Wolf
Communication to / from: From	**Last name:** Solkin
Contact:	**Organization:**
Type of note: Communication with Stakeholder	**Position:**
Created on: 2015-11-09 4:19 PM	**Business phone:**
Created by: Lorne Allaire	**Email:** wolfsolkin@icloud.com

Details

Email from Mr. Solkin follows and is attached:
~~~

[THIS IS TO ACCOMPANY MY LETTER TO MICHEL DOIRON, OF NOVEMBER 2, 2015]

Please provide copy to Mr. Guy Parent.

Sent from my iPad

Begin forwarded message:

> From: Wolf Solkin <wolfsolkin@icloud.com>
> Date: October 2, 2015 at 7:17:29 AM GMT-4
> To: Louise Solkin <louiselanglois.s@gmail.com>
> Subject: OUTCOME of OFFICIAL COMPLAINT by W. W. SOLKIN TO VAC OMBUDSMAN
>
> To all those parties whom this matter may concern:
>
> This statement is being prepared today, October 2nd, 2015, (but held back for distribution until after Oct.9/15), in anticipation of the forthcoming receipt of the official adjudication of my formal complaint, filed on May 27/15, with the Ombudsman of Veterans Affairs Canada, against Mme Rachel Gravel, Executive Director of Ste, Anne's Hospital. Said complaint pertains to certain aspects of Mme Gravel's conduct and actions toward me, which I maintain far exceeded the official mandate/authority of her civiil service position parameters, by suppressing some of my inherent rights as a patient at Ste. Anne's, and also violating my civil rights, as defined in Canada's Charter of Rights and Freedoms (i.e., freedom of thought, belief, opinion and freedom of expression).
>
> The purpose of this memorandum is to go on record, in advance, as to my prediction, assertion and firm conviction that the outcome of the a/m complaint will, as a foregone conclusion, reject the validity and/or justification of my contention(s),plus my request for rectification/vindication, and that, regardless of the true facts of the case, the ruling is pre-ordained to go against me, if for no other reason than that it would hardly do for VAC to suffer embarrassment by rendering a negatively critical statement denigrating "one of their own", particularly in light of her having been recently named (and proudly publicized by VAC) as its recipient of the 2015 "Public Service Employee Award Of Excellence".....presented, no less, by the Governor General at Rideau Hall.
>
> I recognize the sensitivity of the position in which VAC found itself, albeit I am deeply disappointed in how it saw fit to prioritize its components.
>
> Enough said.
>
> Please thank Mr. Michel Doiron for his consideration andi courtesy.
>
> Sincerely,
>
>
> Wolf William Solkin.
>
> Sent from my iPad
~~~

Office of the Veterans Ombudsman

Communication Note Attachment	Attachment File Description
Attachment: Yes	
Created on:	

	Communication Contact Data
Date communication occurred: 2015-11-09 4:18 PM	
Communication method: Email	**First name:** Wolf
Communication to / from: From	**Last name:** Solkin
Contact:	**Organization:**
Type of note: Communication with Stakeholder	**Position:**
Created on: 2015-11-09 4:18 PM	**Business phone:**
Created by: Lorne Allaire	**Email:** wolfsolkin@icloud.com

Details

Email as received from Mr. Solkin follows and is attached:
~~~

Dear Mr. Doiron

This in response your official letter to me, of Oct.19,2015, in which you wrote that I need not hesitate to contact you should I "wish to discuss further". By that, I presume you referred to your
ruling against the validity of my complaint that my inherent and proclaimed rights, as a resident/patient at Ste. Anne's Hospital (SAH), and as a Canadian citizen, to freedom of thought, belief, opinion and freedom of expression, were violated by the actions of the SAH Executive Director, (all as outlined in my formal complaint letter to the Veterans Ombudsman dated May 27/15, and elaborated upon at our only meeting, in Aug/15).

From the content and finality of tone in your letter, I do not believe there to be any point to holding anything resembling a "discussion" which might serve any productive purpose, as it is, of course, impossible to quantify, prove or disprove the all too familiar SAH management's ubiquitous "fire wall" mantra/bugaboo about (potential) vague and looming medical/health consequences. I will, however, take advantage of your invitation, to express some of my observations and comments on your decision. When we met, you told me that my letter of complaint had first been jointly considered/discussed by the Ombudsman and the Deputy Minister of Veterans Affairs Canada (VAC), who then called on you to interview me in order to obtain, first hand, a more in-depth view of the situation, following which you were to present your report to them for their study, so that they would be better enabled to render their ruling.

Accordingly, I was nonplussed to realize that not only did you conduct the inquiry, but you also seem to have personally determined the conclusive judgement, and only then did you submit what appears to be an "FYI" copy of same to Mr. Guy Parent (but not, it seems, to General Walter Natynczyk).
Then again, I note, in your cover email to me, you wrote that you were providing me with..."a copy of my (i.e., your) response to the complaint you (i.e., I) had lodged through the Office of the Veterans Ombudsman-file number OMB15 -014344. I have copied Mr. Parent on this e-mail, so he is aware and can update his file". Hardly the procedure I was led to expect.

I am also puzzled by the fact that when I asked you if you were a member of the Ombudsman's Office, you hastened to disabuse me of any such impression, clearly stating that, to the contrary, you are the "Associate Deputy Minister for Service Delivery", which role entailed several other/ different functions; And yet, notwithstanding, the final verdict was apparently rendered by you, rather than by an accredited official in the Ombudsman's Office, as I had anticipated by so addressing my initial letter of complaint.

You also wrote that you conducted "a thorough review of the case...and a visit to SAH to gather facts and to interview principle (sic) parties". I am curious as to whether you interviewed the Chief Returning Officer and/or her Deputy, who were directly involved parties. More to the point, were you able find time, during your investigation, to interview a proper statistical sampling of what you termed as "...the greater resident population", within which my " strongly worded (initial flyer) had the potential to cause concern..." ?
~~~

Office of the Veterans Ombudsman

It appears to me, from your letter, that you virtually acknowledge, in your words..."that (my) personal rights were infringed...", albeit you seemingly concluded that Mme Rachel Gravel's behaviour toward me, as but one lone individual, was correct and justified in overriding the fundamental fact of my institutional and constitutional rights, on the the sacrificial altar of the greater number, "in support of the hospital's general population".

As an interesting aside, some of your letter's explanatory/justifying words and phrases are readily reminiscent of those with which I have been consistently confronted heretofore by Mme Gravel's traditional "talking points", particularly whenever I protested against the Province's present and/or potential inferior protocols, which she seems so prone to protect from criticism, and which is the predominant cause of my less-than-passive posture, in my efforts to safeguard the future treatment of my fellow-Veterans, as they risk becoming transformed into Provincial ciphers.

Your letter expressed your "...trust (that your decision) brings this matter to a close...". I must confess it is difficult for me to concur with you at this time, as I continue to have lingering doubts, not only about the validity of your conclusion , but also the process and personnel engaged in its formation.

I might well be considered Quixotic in my tilting at the windmills of government bureaucracy and its circle-the-wagons reflexive tactics, but then again, not all windmills are inevitably indestructible, nor inexorably impregnable against the arsenal of public protestation, in defence of one's prized principles and sacrosanct rights.

Regardless of your declared decision /opinion, I am not only a proud Canadian Veteran now living out my life at Ste. Anne's Hospital, under its Charter of Resident's Rights and Responsibilities, but, perhaps of even greater import, is that I am also a proud Canadian Citizen, now living out my life in the country for which I had once voluntarily fought, under the Canadian Charter of Rights and Freedoms, which is above individual, subjective interpretation and dismissal, let alone rescindment..

As Mr. Guy Parent himself recently and openly urged us Veterans..."Go for it, and continue to free the facts"! Sounds like a sound idea !

In conclusion, and by way of demonstrating /verifying that today's email is not a matter of post-facto "sour gripes", I am also sending you, under separate cover, copy of an earlier email I had composed for the attention of the VAC Ombudsman Office , and which I sent to my wife (to withhold), on October 2nd, 2015, well in advance of receipt of your "decision letter " (of Oct.19/15). I did so, purely as a matter of record, to establish that I was already certain that the outcome of my complaint could/would not be in my favour, under any circumstances , regardless of the "facts" which Mr. Parent so eloquently encouraged all Veterans to (set) "free".

I consider the latter communication to be a true harbinger of the treatment my complaint would necessarily receive, regardless of what I, in my very core, hold to be the unquestionable validity of my complaint, which you, in your own view, saw fit to deem as being unworthy of upholding.

Will you please provide Mr. Guy Parent with a copy of this entire correspondence, as I do not have his email address.

Yours truly,

Wolf William Solkin.

Sent from my iPad

Communication Note Attachment	**Attachment File Description**
Attachment: Yes	
Created on:	

Date communication occurred: 2015-10-21 10:09 AM	**Communication Contact Data**
Communication method: Email	**First name:** Guy
Communication to / from: Other	**Last name:** Parent

Office of the Veterans Ombudsman

Contact:	Organization: OVO - Ottawa
Type of note: Communication with VAC/BPA/VRAB	Position: Veterans' Ombudsman
Created on: 2015-10-21 10:09 AM	Business phone: (613) 944-2950
Created by: Lorne Allaire	Email: Guy.Parent@ombudsman-veterans.gc.ca

Details

>>>
From: Guy Parent
To: Cory Micalef; Michel Doiron
Date: 2015/10/21 8:49 AM
Subject: Re: MY FORMAL COMPLAINT TO THE OMBUDSMAN

Merci Michel,
J`espère qu`il sera satisfait.
Guy

Guy Parent
Veterans Ombudsman | Ombudsman des vétérans
Office of the Veterans Ombudsman | Bureau de l'ombudsman des vétérans
Ottawa, Canada
Guy.Parent@ombudsman-veterans.gc.ca
Telephone | Téléphone: 613-944-2950
Facsimile | Télécopieur:613-944-2939
www.ombudsman-veterans.gc.ca
Government of Canada | Gouvernement du Canada
>>> Michel Doiron 2015/10/19 3:11 PM >>>
Mr. Solkin,
Again, please accept my deepest regrets for this delay. Attached please find a copy of my response to the complaint you had lodged through the Office of the Veterans Ombudsman - file number OMB15-014344. I have copied Mr. Parent on this e-mail, so he is aware and can update his file.

I truly hope this information brings the matter to a close for you but please do not hesitate to contact me should you wish to discuss further.

Sincerely, Michel

Michel D. Doiron
Assistant Deputy Minister, Service Delivery Branch / SMA, Secteur de la prestation des services
Veterans Affairs Canada / Anciens Combattants Canada
P.O. Box 7700 / C.P. 7700
Charlottetown, PE C1A 8M9 / Charlottetown, Î.-P.-É. C1A 8M9
Telephone / Téléphone (902) 626-2723 / michel.doiron@vac-acc.gc.ca / Facsimile / Télécopieur (902) 566-8172
Government of Canada / Gouvernement du Canada
http://www.veterans.gc.ca/

>>> Michel Doiron 2015/10/16 11:41 AM >>>
Mr. Solkin,

Please accept my sincere apologies for the delay. I have been out of the office on sick leave, but will provide you with a formal response on Monday.

Michel

Michel D. Doiron

Office of the Veterans Ombudsman

Assistant Deputy Minister, Service Delivery Branch / SMA, Secteur de la prestation des services
Veterans Affairs Canada / Anciens Combattants Canada
P.O. Box 7700 / C.P. 7700
Charlottetown, PE C1A 8M9 / Charlottetown, Î.-P.-É. C1A 8M9
Telephone / Téléphone (902) 626-2723 / michel.doiron@vac-acc.gc.ca / Facsimile / Télécopieur (902) 566-8172
Government of Canada / Gouvernement du Canada
http://www.veterans.gc.ca/

>>> Wolf Solkin <wolfsolkin@icloud.com> 2015/10/16 9:52 AM >>>
Good morning, Mr. Doiron...
Today marks one week to the day, that your last email to me (Sept.30/15) led me, as you wrote, to "expect to have the response (to my formal complaint of May 27/15) ready and sent by Friday, Oct. 9, 2015". I therefore feel I am not being unduly forward in requesting that you now please inform me as to the precise present status of that response, and when I can truly expect to have the final document in my possession.

Whatever the reason for this regrettable delay, I cannot mask my deep disappointment at its occurrence. I do trust that you will now reply to me in timely fashion.

Your courtesy and cooperation in this regard will be most appreciated.

Respectfully,

Wolf William Solkin
Ste. Anne's Hospital
Ste. Anne de Bellevue, PQ.
(514) 505-3914
<wolfsolkin@icloud.com>

Sent from my iPad

Communication Note Attachment	Attachment File Description
Attachment: Yes	
Created on:	

Date communication occurred: 2015-09-09 5:20 PM	**Communication Contact Data**
Communication method: N/A	**First name:** Cory
Communication to / from: Other	**Last name:** Micalef
Contact:	**Organization:** OVO - Early Intervention
Type of note: IO Recommendation	**Position:** Manager, Early Intervention
Created on: 2015-09-09 5:20 PM	**Business phone:** (902) 368-0075
Created by: Lorne Allaire	**Email:** cory.micalef@ombudsman-veterans.gc.ca

Details

Complaint handling taken over by the Deputy Minister. Close file.

Communication Note Attachment	Attachment File Description
Attachment: No	
Created on:	

Date communication occurred: 2015-07-30 2:17 PM	**Communication Contact Data**

Office of the Veterans Ombudsman

Communication method: Email	**First name:** Wolf
Communication to / from: From	**Last name:** Solkin
Contact:	**Organization:**
Type of note: Communication with Stakeholder	**Position:**
Created on: 2015-07-30 2:17 PM	**Business phone:**
Created by: Lorne Allaire	**Email:** wolfsolkin@icloud.com

Details

Email from Mr. Solkin follows and is attached:
~~~
Hello, Mr. Micalef...
I am sending this simply to inquire whether you received (in good/legible condition) the two emails I sent to you on July 22/15, as my iPad has been misbehaving lately.

One email contained text plus an attachment, and the other had text only.

Do please reply and let me know whether I should re-send one or both items., as had been verbally requested by you.

Respectfully,

Wolf William Solkin.

Sent from my iPad

| **Communication Note Attachment** | **Attachment File Description** |
|---|---|
| **Attachment:** Yes | |
| **Created on:** | |

| | **Communication Contact Data** |
|---|---|
| **Date communication occurred:** 2015-07-30 2:13 PM | |
| **Communication method:** Email | **First name:** Wolf |
| **Communication to / from:** From | **Last name:** Solkin |
| **Contact:** | **Organization:** |
| **Type of note:** Communication with Stakeholder | **Position:** |
| **Created on:** 2015-07-30 2:13 PM | **Business phone:** |
| **Created by:** Lorne Allaire | **Email:** wolfsolkin@icloud.com |

**Details**
~~~

Office of the Veterans Ombudsman

Email as received from Mr. Solkin follows and is attached:
~~~
Dear Sir...below is a reproduction of the final "approved " (by Mme Rachel Gravel) version of the "Election Notice"/Flyer which I was eventually permitted to use in the recent election for President of the Ste. Anne's Hospital Residents'Committee (except for typo reversal of my given names).

This will be followed by a second email containing a copy of the previous /original version, which Mme Gravel had refused to allow under any circumstances, which action I deem to have been unwarranted and, more important,an unauthorized and unlawful violation of my rights as a Resident-Veteran at Ste. Anne's, let alone as a Canadian citizen,in addition to being far in excess of her mandated civil service position at Veterans Affairs Canada.

If there is any problem in your receipt of this and/or the succeeding email, please advise.

Many thanks for your prompt attention to this complaint.

Respectfully,

Wolf William Solkin.

| **Communication Note Attachment** | **Attachment File Description** |
|---|---|
| **Attachment:** Yes<br>**Created on:** | |

| | |
|---|---|
| **Date communication occurred:** 2015-07-30 2:11 PM | **Communication Contact Data** |
| **Communication method:** Email | **First name:** Wolf |
| **Communication to / from:** From | **Last name:** Solkin |
| **Contact:** | **Organization:** |
| **Type of note:** Communication with Stakeholder | **Position:** |
| **Created on:** 2015-07-30 2:11 PM | **Business phone:** |
| **Created by:** Lorne Allaire | **Email:** wolfsolkin@icloud.com |

**Details**

Email recived from Mr. Solkin follows and is attached:
~~~
Attention Mr. Cory Micalef....below is the (much bowdlerized and abridged) original version of the Election Notice/Flyer which I submitted to the Secretary of the Election Committee for printing and distribution, but which was adamantly and arbitrarily rejected by Mme Rachel Gravel , all as outlined to you in my initial complaint letter, largely due to my own personal comments, concerns and misgivings regarding the effects upon Ste. Anne's Hospital and its Resident-Veterans, of the forthcoming transfer from Federal to (Quebec) Provincial jurisdiction, which I felt it necessary and important to share with my comrades.

Mme Gravel told me, among other things, that she objected to my negative/disrespectful/deprecating statements about the standards and protocols of Quebec's Health Department., albeit that was the principal purpose and thrust of my thesis.

Do please let me know if I can be of any further assistance in this, to me, so vital an issue that I am prepared to risk possible reprisals /consequences for having initiated this complaint.

Respectfully,

Wolf William Solkin.

Office of the Veterans Ombudsman

Sent from my iPad

Begin forwarded message:

> Subject: Fwd: WW SOLKIN TEXT FOR ELECTION NOTICE (English).....under 300 words; if not, PLS.ADVISE !
>
>
>
> Sent from my iPad
>
> Begin forwarded message:
>
>> From: Wolf Solkin <wolfsolkin@icloud.com>
>> Date: May 14, 2015 at 11:17:56 AM GMT-4
>> To: Nancy Latour <Nancy.Latour@vac-acc.gc.ca>
>> Subject: WW SOLKIN TEXT FOR ELECTION NOTICE (English).....under 300 words; if not, PLS.ADVISE !
>>
>> WOLF WILLIAM SOLKIN: Served as Editor in Chief of "the Veterans' Voice", and Director of the Residents' Committee. Respectfully asking for your vote to elect me as President, so I can continue in your service, especially during the difficult transfer/transition times ahead.
>>
>> #Served in combat as Lieutenant with The Algonquin Regiment in Holland and Germany, until V-E Day and beyond.
>>
>> #Bachelor of Arts, McGill University; Master of Social Work, University of Toronto.
>>
>> We now enjoy"the good life": excellent health care, experienced employees, entertainments, etc., and I am determined to fight to maintain our present level of care and standard of living, and fulfil all other mandated responsibilities of the President.
>>
>> BUT, we are now on the precipice of a very steep cliff, and we'll soon be pushed over into the pit of Quebec's Department of Health, with its poorer protocols of care, staff and services,waiting to infiltrate our lines and our lives.
>>
>> I am convinced, in spite of assurances by Veterans Affairs Canada (VAC) that our standards of care will not be diminished, that once Quebec gains control they will shaft us, unless we take our heads out of the sand of silence, and speak up for ourselves, loud and clear, to the politicians and the public...and it will be my duty to "take the point"!
>>
>> For the next two to three years of the transition, we are going to have one helluva fight on our hands to preserve our way of life and protect what is rightly ours, against our new masters. That very fight is precisely what I am committed to undertake for my SAH comrades, in cooperative harness with a revitalized Residents' Committee, with my leadership as its President.
>>
>>
>>
>> YOUR VOTE WILL BE MUCH APPRECIATED
>>
>> WOLF WILLIAM SOLKIN
>>
>>
>> Sent from my iPad

Communication Note Attachment	**Attachment File Description**
Attachment: Yes **Created on:**	

Office of the Veterans Ombudsman

Date communication occurred: 2015-07-30 2:07 PM	**Communication Contact Data**
Communication method: Email	**First name:** Wolf
Communication to / from: From	**Last name:** Solkin
Contact:	**Organization:**
Type of note: Communication with Stakeholder	**Position:**
Created on: 2015-07-30 2:07 PM	**Business phone:**
Created by: Lorne Allaire	**Email:** wolfsolkin@icloud.com

Details

Via email, from Mr. Solkin:
~~

Dear Sir...below is a reproduction of the final "approved " (by Mme Rachel Gravel) version of the "Election Notice"/Flyer which I was eventually permitted to use in the recent election for President of the Ste. Anne's Hospital Residents'Committee (except for typo reversal of my given names).

This will be followed by a second email containing a copy of the previous /original version, which Mme Gravel had refused to allow under any circumstances, which action I deem to have been unwarranted and, more important,an unauthorized and unlawful violation of my rights as a Resident-Veteran at Ste. Anne's, let alone as a Canadian citizen,in addition to being far in excess of her mandated civil service position at Veterans Affairs Canada.

If there is any problem in your receipt of this and/or the succeeding email, please advise.

Many thanks for your prompt attention to this complaint.

Respectfully,

Wolf William Solkin.

Communication Note Attachment	**Attachment File Description**
Attachment: Yes	
Created on:	

Date communication occurred: 2015-07-29 11:53 AM	**Communication Contact Data**
Communication method: Email	**First name:** Guy
Communication to / from: From	**Last name:** Parent
Contact:	**Organization:** OVO
Type of note: Communication with Stakeholder	**Position:** Veterans' Ombudsman
Created on: 2015-07-29 11:53 AM	**Business phone:** (613) 944-2950
Created by: Lorne Allaire	**Email:** Guy.Parent@ombudsman-veterans.gc.ca

Details

Office of the Veterans Ombudsman

From: Guy Parent
To: Cory Micalef; Guay, Michel
CC: Llisa Blagden; Sharon Squire
Date: 2015/07/29 9:42 AM
Subject: Mr S. SAH case

Hi Michel,
Documents concerning the above case were hand delivered by myself to Deputy Minister Veterans Affairs Canada yesterday afternoon. The DM accepted the case and indicated that he will be taking action, and that we will be informed of the outcomes.
Cory, could you please enter a note to that effect in the file.
thanks
Guy

Guy Parent
Veterans Ombudsman | Ombudsman des vétérans
Office of the Veterans Ombudsman | Bureau de l'ombudsman des vétérans
Ottawa, Canada

Communication Note Attachment	Attachment File Description
Attachment: Yes **Created on:**	

	Communication Contact Data
Date communication occurred: 2015-07-24 10:23 AM	**First name:** Wolf
Communication method: Phone	**Last name:** Solkin
Communication to / from: To	**Organization:**
Contact:	**Position:**
Type of note: Communication with Stakeholder	**Business phone:**
Created on: 2015-07-24 10:23 AM	**Email:** wolfsolkin@icloud.com
Created by: Lorne Allaire	

Details

Call to the Veteran to inform him that we received his email with the information we requested. I told him that I gave copy of his complaint and the additional information he provided to my Director and the Ombudsman for their action. The Veteran said he was extremely pleased with us following up on the matter and the efficient service we have provided him.

Communication Note Attachment	Attachment File Description
Attachment: No **Created on:**	

	Communication Contact Data
Date communication occurred: 2015-07-23 11:50 AM	**First name:** Guy
Communication method: Email	**Last name:** Parent
Communication to / from: To	**Organization:** OVO
Contact:	**Position:** Veterans' Ombudsman
Type of note: Communication with Stakeholder	**Business phone:** (613) 944-2950
Created on: 2015-07-23 11:50 AM	

Office of the Veterans Ombudsman

Created by: Lorne Allaire	**Email:** Guy.Parent@ombudsman-veterans.gc.ca

Details

\>>>
From: Cory Micalef
To: Guay, Michel; Parent, Guy; Squire, Sharon
Date: 2015/07/23 10:28 AM
Subject: Wolf Solkin Complaint

Good morning,

Herewith attached is the information we requested from the Veteran as well as the complaint submitted to the OVO.

Solkin Flyer
Page 1 : Email to me

End of page 1 and 2: The initial content he submitted by email to be printed on the flyer that was subsequently not permitted.

Page 3 : The final flyer

Solkin Letter
The complaint letter sent to the OVO.

If you need additional information please let me know.

Communication Note Attachment	**Attachment File Description**
Attachment: Yes	
Created on:	

Date communication occurred: 2015-07-21 5:17 PM	**Communication Contact Data**
Communication method: Phone	**First name:** Wolf
Communication to / from: To	**Last name:** Solkin
Contact:	**Organization:**
Type of note: Communication with Stakeholder	**Position:**
Created on: 2015-07-21 5:17 PM	**Business phone:**
Created by: Lorne Allaire	**Email:** wolfsolkin@icloud.com

Details

Call to the Veteran to request that he send us a copy of the content he submitted to be printed on the pamphlet that was to be distributed for the election for President of the residents of Sainte -Anne Hospital. The Veteran said he was very pleased that the OVO is following up in the matter.
He said he is more than willing to provide us with the information. He said he will send both the initial content he submitted that was refused, as well as the "acceptable" version that was printed on the pamphlet.

Communication Note Attachment	**Attachment File Description**
Attachment: No	
Created on:	

Date communication occurred: 2015-06-17 2:40 PM	**Communication Contact Data**

Office of the Veterans Ombudsman

Communication method: Phone	**First name:** Wolf
Communication to / from: To	**Last name:** Solkin
Contact:	**Organization:**
Type of note: Communication with Stakeholder	**Position:**
Created on: 2015-06-17 2:40 PM	**Business phone:**
Created by: Lorne Allaire	**Email:** wolfsolkin@icloud.com

Details

The Veteran explained that his rights to free speech were violated and that he was not treated with respect as per the Veteran Bill of Rights. He said as a candidate for the election he submitted the information to be printed on the leaflet as required. He was told by the civil servant in charge that she will in no way let that leaflet circulate in her hospital. He added that she overstepped her mandate and treated him without respect as a citizen and a Veteran. He would like her to be reprimanded and that the scope of her mandate be clarified to her. I informed the Veteran that I would look into the matter and get back to him.

Communication Note Attachment	Attachment File Description
Attachment: No	
Created on:	

	Communication Contact Data
Date communication occurred: 2015-06-17 2:33 PM	
Communication method: Email	**First name:** Wolf
Communication to / from: From	**Last name:** Solkin
Contact:	**Organization:**
Type of note: Consent - Provided	**Position:**
Created on: 2015-06-17 2:33 PM	**Business phone:**
Created by: Lorne Allaire	**Email:** wolfsolkin@icloud.com

Details

Consent given to read VAC files and to communicate with VAC on his/her behalf, as needed.

Communication Note Attachment	Attachment File Description
Attachment: No	
Created on:	

	Communication Contact Data
Date communication occurred: 2015-05-27 3:21 PM	
Communication method: Email	**First name:** Wolf
Communication to / from: From	**Last name:** Solkin
Contact:	**Organization:**
Type of note: Communication with Stakeholder	**Position:**
Created on: 2015-05-27 3:21 PM	**Business phone:**
Created by: Lorne Allaire	**Email:** wolfsolkin@icloud.com

Details

Email as received from Mr. Solkin follows and is attached:

Office of the Veterans Ombudsman

~~~

I am a WW II Veteran, now in "permanent" residence at Ste. Anne's Hospital . I was a member/director of the soon-to-be outgoing Residents' Committee , plus having been the creator, writer and Editor-in-Chief of "The Veterans' Voice", an innovative , in-house newsletter dedicated to the cause and concerns of the Veteran population quartered at Ste. Anne's.

I am now a candidate for the office of president of the SAH Residents' Committee. The election date is set for May 29/15, and therefore I wish to go on record with my complaint before that date, "win, lose, or draw", so that it may not be misconstrued as a matter of " sour gripes ", should the end result not be in my favour. While reluctant to bring this issue to the fore before now, I have finally permitted principle to prevail over politesse.

After my nomination document was properly submitted, I received a call requesting that I meet with the official volunteer (Mme Mychele Amberg) selected as "Election Returning Officer". Also present were Mme Nancy Latour, a staff member designated to be "Deputy Returning Officer"/Secretary, and Mme Joanne Grondin, another staff member, who had been appointed by "Management", as a (rotational) temporary Ombudsman, in situ.

The purpose of that meeting was to present me with a typed document, signed by the Returning Officer and her Deputy, which was titled as follows:
"2015-2018 Elections - Residents' Committee
Information on the election/campaign process for presidential candidates".

The contents of the a/m document was, in essence, a short set of fairly straightforward rules and regulations governing such items as: conduct of the election process; permitted size of written campaign/election notices; date and place(s) of voting; and the like. Those stipulations and conditions were then discussed on an item-by-item basis, and subsequently accepted .

At no time did the document itself, nor any of part of the discussion related to it, make any reference whatsoever to restrictions of any kind or nature pertaining to the subject matter/ content, wording, writing style , tone. etc., of the "text" of the permitted "election notice" (i.e., campaign flyer). The only stated submission requirements were/are that it be " ... a bilingual text with a maximum of 300 words written by the candidate to be submitted to the election secretary no later than May 15, 2015 (and)...can be printed in format 8.5 x 11...so that candidates can distribute them...".

Shortly after having submitted the text of my election notice/flyer in full accordance with all the declared conditions quoted and/or referred to above, I was summarily summoned to the office of Mme Rachel Gravel, the current Executive Director of Sre. Anne's Hospital, who informed me, in no uncertain terms, that under no circumstances would she ever allow my election notice, as originally conceived and duly submitted by me, to be printed by her Communications and Commemoration Directorate, let alone be posted and/or circulated anywhere in (her) hospital !

[Note that the main theme of my thesis was the impending injurious effects upon Ste. Anne's Hospital and its vulnerable Veterans, of the upcoming transfer from Federal to Provincial/Quebec command and control].

I admit to having been more than merely taken aback by what I deemed to be such an egregiously unilateral and autocratic decision (which I believe/d to be both unwarranted and unlawful). When I asked to know the reasons for her unyielding draconian stance, Mme Gravel told me (and I both paraphrase and quote, to the best of my nonagenarian capacity for recall), that she personally considered the wording and tone of my text to be entirely too improper and unacceptably confrontational, aggressive , and denigrating toward The Province of Quebec and its Health Department. Nor was I to make reference to what are (in my opinion and that of others) the lower standards of care, poorer staff-to-patient ratios, and less professionally effective protocols under the aegis of Quebec, than are to be found within our current Federal governance.

Mme Gravel's other major objection was that she was convinced my envisioning and portraying future damoclean problems and concerns affecting my fellow-resident/patients, which disruptive difficulties I am confident will be spawned by the forthcoming transfer/transition of Ste, Anne's Hospital from Federal to (Quebec's) Provincial jurisdiction, would only serve to make our Residents and their families anxious and disquieted about their future fate. It should, perhaps be noted here that my views are, coincidentally, diametrically opposed to the position manifested in a recent letter from Mme Gravel to all patients' families, expressing her open optimism, coupled with her emphatic assurances of a virtually seamless transition, which would patently redound to the benefit of all souls involved, and so the transfer need not be feared as a threat to anyone, all as personally vouchsafed by her.
~~~

Office of the Veterans Ombudsman

When I inquired as to what were my options , Mme Gravel unhesitatingly and firmly replied that I could agree to re-write my election notice/flyer in bowdlerized form to her personal satisfaction, i.e., deleting any and all, in her own opinion, so-called negative , controversial, provocative or disturbing references to a possible tsunami of transfer-transition troubles, and replace them with more reassuring and positive material***. If I were unwilling to comply with that directive, I could then elect (pun notwithstanding) to conduct my election campaign without the aid of any supporting printed material whatsoever. Failing that course of (in)action, of course the final option would appear to be clearly inevitable (even to one at my advanced age and stage).

Which finally(!) brings me to the complaint which I now must needs draw to your attention : I am of the conviction that Mme Rachel Gravel, in her Federal civil-service employee capacity as Executive Director of Ste. Anne's Hospital, has, as displayed in her above-described conduct toward me, far exceeded the defined and mandated authority, powers and limitations of the official job description of her position and government employee classification or category, and that she should therefore be subject to whatever action s are indicated, in accordance with the applicable CVA prevailing process and protocols,should my contention indeed prove to be upheld.

On the other hand, if it is determined that I am wrong on all counts in my assumptions, and my complaint is wholly unfounded in the ruling /opinion of the VAC Ombudsman, I will unhesitatingly personally apologize and grovel before Gravel, for having wrongfully complained about her a/m actions toward me.

I have here attempted, insofar as possible for me , to present the straight facts, avoiding I.
Pany undue enhancement of the case by injecting my emotional response to what I objectively consider to be an outright and blatant violation of my rights and privileges, as delineated for the treatment of Veterans by VAC employees in the applicable DVA "charter" of yore; let alone as an ordinary Canadian citizen, for whose rights to freedom of speech and of expression many of us once fought so fiercely to protect and preserve.

***I ultimately decided, under both pressure and protest, to "choose door no.1", perforce putting pragmatism before principle and pride, if I might yet have the opportunity to effectively craft beneficial changes from within the existing structure and venue, rather than be limited to punier progress by protest from beyond the pale.

You have my permission to access my VAC file, and I will genuinely appreciate your anticipated response.

Respectfully,

Wolf William Solkin
Ste. Anne's Hospital
Room T-11 / 14
VAC file no. K4730362
tel. (514) 505-3914
<wolf solkin@icloud.com>

Sent from my iPad
~~~

Communication Note Attachment	Attachment File Description
Attachment: Yes	
Created on:	

Summary of Facts

Client Expectation

He would like the civil servant in charge at Sainte-Anne Hospital to be reprimanded and that the scope of her mandate be clarified to her.

Client Perspective
~~~

Office of the Veterans Ombudsman

The Veteran submitted the content he wanted printed on a flyer for the election of President of the residents of SAH and was informed in a disrespectful manner by the Director that he either modify and resubmit the content for her approval or risk having no flyer printed to help him in his campaign. The Veteran feels his rights as a citizen and Veteran were violated and that the Director overstepped her mandate.

Departmental Position

After being informed of the Veteran's concernsby the Obudsman. the Deputy Minister has stated he will be following up on the matter and will keep the OVO informed of the outcome.

Assessment

Intervention Officer

Assessment

Cory Micalef: The Veteran's right to free speech was infringed upon by the Director of SAH as she censured the message on his campaign pamphlet. Deputy Minister Is has met with the Ombudsman and will personally look into the matter he said.:

Action Taken

Cory Micalef: Call to the Veteran
Discussed with the OVO Director
Provided information/documents submitted by the Veteran to Senior Mangement for action.

Summary Annex

None

File Closing Information

Success Story: N/A

Findings: Other

Closing Outcome:

File Assignment History

Action	Date	By	File Type	Reason
Assigned To: Cory Micalef	2015-06-17 2:40 PM	Cory Micalef	Complaint	
Assigned To Inventory	2015-05-27 3:21 PM	Daren Dixon	Complaint	

File Summary List

Type	Original Owner	Details
OSR Action Taken	Cory Micalef	Call to the Veteran Discussed issue with Director and the Ombudsman

No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

WOLF WILLIAM SOLKIN

Plaintiff

vs.
THE ATTORNEY GENERAL OF CANADA
-and-
THE ATTORNEY GENERAL OF QUEBEC
-and-
THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

LIST OF EXHIBITS AGC-1 TO AGC-25
IN SUPPORT OF THE DEFENCE
OF THE ATTORNEY GENERAL OF CANADA

EXHIBIT AGC-25

Attorney General of Canada

Department of Justice Canada
Québec Regional Office
Guy-Favreau Complex, East Tower, 9th Floor
200, René-Lévesque West Blvd.,
Montréal (QC) H2Z 1X4
Fax : (514) 283-3856 / NotificationPGC-AGC.Civil@justice.gc.ca

Per : Me Nathalie Drouin
Tel: (514) 283-8117
E-mail: Nathalie.drouin@justice.gc.ca

Per : Me Sébastien Gagné
Tel : (514) 283-7157
E-mail : Sebastien.gagne@justice.gc.ca

Per : Me Mariève Sirois-Vaillancourt
Tel : (514) 283-5553
Marieve.Sirois-Vaillancourt@justice.gc.ca

Per : Me Amélia Couture
Tel : (514) 283-6312
Amelia.Couture@justice.gc.ca

O/Ref : 9683661 BC0565

No. 500-06-000952-180

SUPERIOR COURT
Class Action – District of Montréal

WOLF WILLIAM SOLKIN

Plaintiff

vs.

THE ATTORNEY GENERAL OF CANADA

-and-

THE ATTORNEY GENERAL OF QUEBEC

-and-

THE CENTRE INTÉGRÉ UNIVERSITAIRE DE SANTÉ ET DE SERVICES SOCIAUX DE L'OUEST-DE-L'ÎLE DE MONTRÉAL

Defendants

LIST OF EXHIBITS AGC-1 TO AGC-25
IN SUPPORT OF THE DEFENCE
OF THE ATTORNEY GENERAL OF CANADA

ORIGINAL

Attorney General of Canada

Department of Justice Canada
Québec Regional Office
Guy-Favreau Complex, East Tower, 9th Floor
200, René-Lévesque West Blvd.,
Montréal (QC) H2Z 1X4
Fax : (514) 283-3856 / NotificationPGC-AGC.Civil@justice.gc.ca

Per : Me Nathalie Drouin
Tel: (514) 283-8117
E-mail: Nathalie.drouin@justice.gc.ca

Per : Me Sébastien Gagné
Tel : (514) 283-7157
E-mail : Sebastien.gagne@justice.gc.ca

Per : Me Mariève Sirois-Vaillancourt
Tel : (514) 283-5553
Marieve.Sirois-Vaillancourt@justice.gc.ca

Per : Me Amélia Couture
Tel : (514) 283-6312
Amelia.Couture@justice.gc.ca

O/Ref : 9683661 BC0565