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Chair

Mr. Bill Casey

Standing Committee on Health

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• (1100)

[English]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I call our meeting to order.

Welcome to meeting number 62 of the health committee. We are going to continue our study on antimicrobial resistance. We have four groups of witnesses today, so we will have four opening statements. They are going to be limited to 10 minutes, and I am going to be very tough today. I hate interrupting people, but I may have to if you go over 10 minutes, because we're tight on time.

I'll introduce our guests. Thank you very much for coming.

Dr. Andrew Morris is chair of the antimicrobial stewardship and resistance committee of the Association of Medical Microbiology and Infectious Disease Canada. From the Canadian Nurses Association, we have Karey Shuhendler, policy adviser for policy, advocacy, and strategy, and Yoshiko Nakamachi, antimicrobial resistance nursing expert. From the Canadian Pharmacists Association, we have Shelita Dattani, director of practice development and knowledge translation. From the Royal College of Physicians and Surgeons, we have Dr. Michael Routledge, medical officer of health, Southern Health regional health authority.

We are going to start with the Association of Medical Microbiology and Infectious Disease. Dr. Morris, you have 10 minutes.

Dr. Andrew Morris (Chair, Antimicrobial Stewardship and Resistance Committee, Association of Medical Microbiology and Infectious Disease Canada): Thank you.

Mr. Chair and honourable members, I am honoured to have the privilege and opportunity to present to you on antimicrobial resistance.

I come to you as chair of the antimicrobial stewardship and resistance committee of the Association of Medical Microbiology and Infectious Disease Canada. We represent the medical specialists in Canada with expertise in antimicrobial resistance: how it develops, how to prevent it, and how to manage it.

I am also a practising academic infectious diseases physician, running the country's oldest and largest antimicrobial stewardship program at Sinai Health System and University Health Network in Toronto.

I want you to know that I became an infectious diseases physician so that I could cure people. Antibiotics are used to cure, miraculously. This book, titled *The Clinical Application of Antibiotics: Penicillin*, is from 1952. As you can see, it is 700 pages long, and it describes the miracle of penicillin. If we were to revise it today, it would be about 100 pages long, as most of penicillin's utility in medicine has been lost because of resistance. In fact, most doctors today don't even know how to prescribe penicillin.

Antibiotics, to infectious diseases physicians, are like scalpels to surgeons. The only difference is that infectious diseases physicians don't really get the glory; the antibiotics do. That heuristic of reliably curing people with antibiotics ended for me relatively early in my career, about 14 years ago, when I was taking care of a young man—a husband and a father—in Hamilton, Ontario, where I was working at the time. He had a brain infection due to a drug-resistant bacterium. It became resistant because it was repeatedly exposed to the antibiotics he was receiving. I had to use what at the time was relatively experimental therapy. He died, either despite me or because of me.

That event, which was the critical event of what I had seen emerging over the years prior, due to overuse of antimicrobials, has shaped what I do today, and it leads me to what I want to cover with you in the next few minutes.

First, what is antimicrobial resistance? Antimicrobial resistance, or AMR, is basic Darwinian selection. Bacteria in the environment—in humans, animals, birds, or aquaculture—are exposed to antibiotics, and as many of the drug-susceptible bacteria die off, bacteria that have randomly developed a mutation rendering them resistant to the antimicrobials thrive. There are only two things required for antimicrobial resistance to develop: bacteria and antimicrobial use. When the drug-resistant genes in bacteria take hold in a community or a population, the ability to reverse the growth of drug resistance ends up being rather uncertain.

Why should the House Standing Committee on Health and the Canadian public care about AMR? Canadians pride themselves on their health care. They have come to expect safe pregnancy and delivery, including C-sections; neonatal care; management of common infections such as pneumonia and urinary tract infections; routine surgeries such as appendectomy, cardiac surgery, and joint replacement; cancer care; and even organ and stem cell transplantation. These are all threatened by antimicrobial resistance.

For some of these conditions, it is actually a present-day threat, rather than a future one. Up to half of the pathogens causing infections in cancer and surgery are already resistant to first-line antibiotics in the U.S. I would like to quote Canadian data, but we don't really have reliable ones. It is likely comparable.

Whereas untreatable infections were unheard of when I first started practising medicine, physicians like me are already routinely seeing patients for whom we are using novel therapy to treat routine infections. Many antibiotics are rendered so obsolete by drug resistance that manufacturers have stopped producing them and clinicians have stopped learning about them.

When I started practising medicine, the only common AMR acronym in our lexicon was MRSA, methicillin-resistant *Staph aureus*. Today, that list also includes KPC, ESBL, NDM-1, VRE, and CDI, and the list goes on.

These all cost the health care system billions of dollars. This is juxtaposed with the over \$1 billion we spend on prescription antibiotics in Canada, about half of the use of which is unnecessary. More important, it is an overall threat to national security. It threatens Canadians in a manner greater than violence and accidents combined.

AMR doesn't have headlines. When a woman needing a lung transplant recently ran out of effective antibiotic options to keep her alive, the story in the media was on the heroic removal of the infected lungs and keeping her alive, rather than the fact that she had a tipping point of completely drug-resistant infection.

● (1105)

AMR has no walks, runs, bike rides, golf tournaments, or galas. It has no ribbon, and the pharmaceutical industry has either distanced itself from antimicrobial development or fought to prioritize drug innovation over antimicrobial stewardship, or the wise use of antimicrobials.

What is needed to tackle AMR? Almost a year ago today, on June 16 and 17, I co-chaired the national action round table on antimicrobial stewardship, co-hosted by HealthCareCAN and NCCID. That event included 50 thought leaders and stakeholders from across all sectors, some of whom you will hear from today. We came up with a menu of what needs to get done.

For starters, convene and fund a national network to coordinate stewardship, herein known as AMS Canada; nominate executive leads on AMS at the federal, provincial, and territorial levels for strategic planning and implementation; enhance accreditation for AMS; support and scale up core operations in hospital-based AMS; enhance awareness of AMR and AMS among prescribers and public; establish an AMS or antimicrobial stewardship research and development fund; develop and support core datasets in AMU or

antimicrobial utilization surveillance; incent community prescribers, using audit and feedback mechanisms; develop national guidelines for antimicrobial prescribing and mechanisms to promote adoption; and finally, develop a network of centres of excellence in knowledge mobilization for AMS.

As I mentioned, that was one year ago, almost to the day, and what has happened? Its the same thing that happened with the 2004 report, "National Action Plan to Address Antibiotic Resistance", and the 2009 report following pan-Canadian consultation by the since-defunded Canadian Committee for Antibiotic Resistance.

In 13 years, we have had three national reports on antimicrobial resistance, and the collective response from the federal government remains a tacit one. In fact, the Public Health Agency has all but eliminated any anticipated funding towards antimicrobial stewardship and surveillance for the upcoming year. "Suspended" is the term we have been given. This pales in comparison to the United States, which spends over \$1 billion annually to combat antimicrobial resistance, with an effort that includes the Departments of Defense, Justice, and Homeland Security, amongst other departments. The United Kingdom has equally provided strong leadership and effort, with their chief medical officer of health, Dame Sally Davies, perhaps the strongest world advocate on the subject.

In Canada, antimicrobial stewardship and resistance research funding is less than \$10 million per annum. More has been announced recently, but this compares with CIHR funding of \$273 million for cancer or oncology, which has another \$95 million from the Ontario cancer institute, \$91 million from the Fonds de recherche du Québec—Santé, and numerous other research sources.

I could go on, but suffice it to say that, in Canada, antimicrobial resistance is not being sufficiently addressed. This is reinforced by our own Auditor General who two years ago concluded that the Public Health Agency of Canada and Health Canada "have not fulfilled key responsibilities to mitigate the public health risks posed by the emergence and spread of antimicrobial resistance in Canada."

The Auditor General also stated that the Public Health Agency of Canada:

has not determined how it will address the weaknesses it has identified in its collection, analysis, and dissemination of surveillance information on antimicrobial resistance and antimicrobial use. The Agency has taken some steps to promote prudent antimicrobial use in humans, such as developing and disseminating guidelines for health professionals, but has identified the need for more guidelines.

Honourable committee members and Mr. Chair, on behalf of AMMI Canada, I stand here to tell you that Canada has been lucky to avoid an antimicrobial resistance catastrophe. I am not a boy crying wolf. There were warning signs around opiates for decades and they only became front of mind when the deaths escalated, researchers started identifying the public health crisis, and civil society took notice. Governments have had to play catch-up ever since.

Today, I represent the voices of Canada's experts on infectious diseases and antimicrobial resistance telling you that the current situation and the crisis that we will be facing will be like it is with opioids, only worse. The victims will span all ages. Our health care system will be paralyzed. The costs of ignoring AMR today will be paid many times over in lives lost. When the post-mortem will be done, as it was for the Naylor report following SARS, the country will look to missed opportunities and ignored warning signs. You have an opportunity to heed those warning signs.

Thank you for your attention.

• (1110)

The Chair: Thank you. You pack a lot into 10 minutes. It's most impressive.

We'll move on to the Canadian Nurses Association.

Karey.

Ms. Karey Shuhendler (Policy Advisor, Policy, Advocacy and Strategy, Canadian Nurses Association): Thank you, Mr. Chair.

Good morning, Mr. Chair, and members of the committee. My name is Karey Shuhendler. I'm a registered nurse and policy adviser with the Canadian Nurses Association, the national professional voice for over 139,000 registered nurses and nurse practitioners in Canada.

I'm pleased to be here with Yoshiko Nakamachi, who is with us today as CNA's antimicrobial resistance nursing expert. She will be able to answer questions that may be more technical in nature. Yoshi currently serves as the antimicrobial stewardship program lead and program manager at the Sinai Health System and University Health Network antimicrobial stewardship program in Toronto. She has also worked with community hospitals to develop antimicrobial stewardship programs, is involved in a multicentre antimicrobial stewardship initiative in primary care, and is a member of provincial, national, and FPT antimicrobial stewardship committees.

At the outset, I'd like to thank the committee for studying this important issue and for giving CNA the opportunity to speak on behalf of registered nurses and nurse practitioners. We have a professional responsibility to advocate for federal action on antimicrobial stewardship, henceforth referred to as AMR, as it is a major threat to the health of people in Canada and is projected to worsen over time if appropriate actions are not taken. As you may know, antimicrobial resistance occurs when an organism, like a bacteria or virus, stops an antimicrobial medication from working against it. This means standard treatments no longer work, and infections can persist and spread to others. AMR leads to increased human illness, suffering, and death; increased costs and length of treatment; and increased side effects from the use of multiple and increasingly powerful medications.

Prior to outlining our two key recommendations and taking your questions, we want to paint a picture of the impact of AMR internationally, as well as providing some national context.

The director general of the WHO has referred to AMR as a "slow moving disaster", one of the most serious threats to human health and safety. The WHO has also warned that AMR is putting the gains of the millennium development goals at risk and endangering the achievement of sustainable development goals. AMR is an issue that requires action by all areas and disciplines in health.

In its 2017 position statement on AMR, the International Council of Nurses notes:

Nurses and other healthcare workers have a vital role to play in preserving the power of antimicrobial medicines. Nurses play a central role in patient care and interdisciplinary communication and, as such, are in a key position to contribute to reducing AMR and critical for the function of antimicrobial stewardship programmes (ASP).

The statement goes on to point out that nurses contribute to assessment and diagnoses of infections, administer and may prescribe antimicrobials, monitor outcomes and report side effects, provide vaccinations, and educate patients, families, and communities.

At the national level, CNA acknowledges the planning efforts of the federal government to respond to the threat of AMR through the development of the 2014 document "Antimicrobial Resistance and Use in Canada: A Federal Framework for Action", the 2015 document, "Federal Action Plan on Antimicrobial Resistance and Use in Canada: Building on the Federal Framework for Action", and the 2017 draft document, "Tackling Antimicrobial Resistance and Antimicrobial Use: A Pan-Canadian Framework for Action".

CNA has also been doing its part to combat AMR by contributing to national work on infection prevention and on stewardship. Do Bugs Need Drugs?, a community-based antimicrobial stewardship program in B.C. and Alberta, defines "stewardship" as:

...the practice of minimizing the emergence of antimicrobial resistance by using antibiotics only when necessary and, if needed, by selecting the appropriate antibiotic at the right dose, frequency and duration to optimize outcomes while minimizing adverse effects. The principles of antimicrobial stewardship apply wherever antimicrobial agents are used including hospitals, long term care facilities, community medicine, agriculture and veterinary use, and in the home and community.

CNA's efforts in this area include membership and participation on the antimicrobial stewardship or AMS Canada steering committee, and engaging in the Canadian Roundtable on AMS to develop a Canadian multidisciplinary, multi-sectoral action plan on antimicrobial stewardship.

We are also active participants in the federal-provincial-territorial AMR stewardship task team to develop a pan-Canadian framework and action plan. In addition, through partnering with Choosing Wisely Canada, a national program to engage clinicians and patients in conversations to reduce overuse, CNA has developed a broad list of nursing recommendations to reduce the use of tests, treatments, and interventions that may lack benefit or cause harm. Several of these recommendations advance the AMS agenda, including recommendations to reduce inappropriate or unnecessary use of antimicrobials.

CNA is planning to release a speciality Choosing Wisely nursing list, in partnership with Infection Prevention and Control Canada. This list includes recommendations to reduce the use of interventions that can lead to infection, as well as reducing inappropriate laboratory testing, which can lead to unnecessary use of antimicrobials. It also includes stewardship recommendations focused on reducing inappropriate antimicrobial use.

•(1115)

Despite work done by CNA and other partner organizations across the country, additional effort and investment is required by the federal government to further address antimicrobial use and resistance. Of particular note is the need to emphasize an interprofessional approach to stewardship that includes nurses, in collaboration with physicians, pharmacists, patients, and caregivers, as a cost-effective preventative approach to AMR.

We have two key recommendations to address the issue of AMR in Canada with a focus on stewardship. We encourage the committee to include these recommendations in your final report on this important study.

Our first recommendation encourages the federal government to support the 10 action items on antimicrobial stewardship put forward in HealthCareCAN and the National Collaborating Centre for Infectious Diseases document entitled “Putting the Pieces Together: A National Action Plan on Antimicrobial Stewardship”. The 10 items are outlined in CNA’s brief, but also nicely summarized by Dr. Morris.

Our second recommendation urges that the federal government commit to providing significant funding over the next five years to support scaling up of antimicrobial stewardship programs across acute care and community-based settings in the provinces and territories, conditional on an accountability framework, and that the federal government support the role of nurses in antimicrobial use, resistance, and stewardship.

Why is funding needed? Historically, education and reform around antimicrobial use and stewardship has been targeted to physicians and pharmacists but not to regulated nurses, who make up the largest group of health care professionals in Canada.

According to the Canadian Institute for Health Information’s report entitled “Regulated Nurses, 2016” and released just last week, there are more than 400,000 regulated nurses in Canada. This number represents over 100,000 licensed practical nurses, approximately 6,000 registered psychiatric nurses, and nearly 300,000 registered nurses, including 5,000 nurse practitioners. Nurses are present in every health setting. They are well positioned to contribute

to antimicrobial stewardship, for the preservation of health and the improvement of health outcomes for all people in Canada.

I would like to close with the reminder that antimicrobial resistance is a national and international issue with local implications. Every person in Canada, including those who live in the ridings that each of you represent, is not immune from the evolving threat of AMR. That is why immediate action by the federal government is required.

CNA encourages the Standing Committee on Health to urge the federal government to adopt all 10 expert-developed recommendations in “Putting the Pieces Together: A National Action Plan on Antimicrobial Stewardship” as a key component of addressing antimicrobial use and resistance in Canada.

Furthermore, the federal government can take additional concrete action by investing in established AMS programs with proven results to reduce inappropriate antimicrobial use, and by investing in the education of nurses to leverage their potential as antimicrobial stewardship leaders across all health settings in Canada.

Thank you.

•(1120)

The Chair: Thank you very much.

Now we’ll go to the Canadian Pharmacists Association, with Ms. Dattani.

Ms. Shelita Dattani (Director, Practice Development and Knowledge Translation, Canadian Pharmacists Association): Good morning, everyone, and thank you for the opportunity to be here today.

My name is Shelita Dattani, and I am the director of practice development and knowledge translation at the Canadian Pharmacists Association, which is the national voice of Canada’s 42,000 pharmacists. I am also a practising hospital and community pharmacist and have significant experience leading and participating in antimicrobial stewardship initiatives in the hospital setting.

Since the discovery of penicillin by Sir Alexander Fleming in 1945, as my colleague described, antibiotics have made an enormous contribution to the treatment of infectious disease, and they have made so many other treatments and procedures, such as surgeries and transplants, possible for us.

It is worth echoing my colleagues here today that AMR has been described as a “slow moving disaster”. As others have said, it is a very serious threat to health and public safety. If left unchallenged, it could lead to 10 million deaths a year by 2050, and with few new antibiotics in current drug development, it’s frightening. It’s everyone’s problem, and everyone must be part of the solution.

I want to talk to you today about antimicrobial stewardship and the role of the pharmacist.

As others have said, stewardship is a team sport, and our collective goal in antimicrobial stewardship is ensuring that patients get the right antibiotics when they need them, and only when they need them. As the medication experts, pharmacists are fundamental to antimicrobial stewardship. Hospital pharmacists throughout this country have demonstrated leadership in antimicrobial stewardship activities and programs for several years now. Just as I spent much of my time in hospital practice ensuring that patients were receiving the right antibiotics, and only if they needed them, I work with my primary care colleagues now to do the same when I practise at the neighbourhood pharmacy. Pharmacists can act as stewards throughout the continuum of care, as other professions can. We work in hospital settings, long-term care settings, primary care teams, public health, and the area that I will predominantly focus on today, which is community pharmacy.

Hospitals and long-term care environments have either established or evolving stewardship programs, but over 80% of antibiotics are prescribed in the community, where few formal antimicrobial stewardship programs currently exist. One large study published last year in the *Journal of the American Medical Association* demonstrated that 30% of antibiotic use in non-hospitalized patients is unnecessary.

Antibiotic prescribing in the community is driven by the tendencies of individual prescribers and consumer demand. Community pharmacists have the skills and knowledge to make a real difference. Pharmacists like me, in communities across this country, have established relationships with their patients and their prescriber colleagues. Pharmacists can effect real change in community-based antibiotic prescribing.

There are five key areas in which pharmacists are demonstrating leadership as antimicrobial stewards in the community. These include public education, immunization, prescribing for minor ailments, counselling patients, and optimizing prescribing by other health care providers.

Many Canadians are unaware of the impact and the risks of inappropriate antibiotic use compared with the benefits. Pharmacies are the hubs of their local communities, and pharmacists can play a big role in health promotion and transforming patients into stewards. As others have mentioned, educational campaigns in Canada, such as the community-based education program *Do Bugs Need Drugs?* and the *Choosing Wisely* campaign, include antibiotic-related information. Pharmacists have participated in the development of these campaigns. They are developing their own lists for these campaigns, and they are relaying the messages to their patients each and every day in the hubs of their communities.

For several years, Canadians have been able to go to their community pharmacy to get their flu shots. One of the best opportunities I have to talk to my patients about infection prevention, symptomatic management of viral infections, or their hesitancy in getting vaccinated in the first place is during flu shot season. I tell my patients that vaccinations don't just prevent primary infections, but they can also prevent secondary infections from antibiotic-resistant bacteria, for example, pneumonias that can follow flu infections. I use these opportunities around flu season to talk about the importance of all vaccinations.

Beyond this, pharmacists are also taking on more active, targeted, and patient-specific interventions that you may not be aware of, which include assessment, treatment, and follow-up of their patients. Because pharmacists see their patients on average 14 times a year—sometimes at nine o'clock on a Thursday night, or maybe at 4 p.m. on a Sunday—they are very well placed to provide direct care to patients.

In one province in this country, pharmacists can independently prescribe broadly, and in a few others, can prescribe more specifically for minor ailments like uncomplicated urinary tract infections or strep throat. Pharmacists are guideline-oriented practitioners, and they are very invested, as I mentioned, in campaigns like *Choosing Wisely's* "More is not always better". As drug experts, prescribers, and antimicrobial stewards, we pharmacists are very conscious of responsible prescribing—and more importantly, not prescribing if not needed.

● (1125)

In certain provinces, pharmacists can substitute one antibiotic for another. For example, if you come into your pharmacy and you have allergies to the antibiotic prescribed, or if the initial antibiotic prescribed does not resolve your infection, I can substitute a more appropriate antibiotic. I have a relationship with you; I can do that.

These expanded scopes mean that pharmacists have a very direct opportunity to lead in antimicrobial stewardship. There is currently research under way in the province of New Brunswick to capture outcomes in patients assessed and treated by their pharmacists for uncomplicated urinary tract infections.

Pharmacists can also help support their physician colleagues who use delayed prescribing, which is a debatable practice. If a patient gets a prescription from their doctor and is instructed to start antibiotics if symptoms do not improve after a specified time, I can reinforce symptom management with my patient to ensure that we don't jump to antibiotics too quickly. I can counsel my patient on when to follow up with her prescriber. If my patient ends up needing antibiotics, I will talk to her in detail about benefits but also the other things she may not be thinking about, such as the adverse effects and other unintended consequences that have been described here today.

Rapid strep tests are also now offered in some pharmacies. Pharmacists can administer these tests and intervene immediately, either through prescribing or recommending antibiotics or over-the-counter treatments for viral illnesses, as appropriate. Expanding these services would further relieve pressure on the health care system if patients were able to avoid emergency departments or urgent care clinics. A U.K. demonstration study showed that 49% of patients would have sought care from their family doctor if strep tests were not accessible and available in community pharmacies, which are the health care hubs of their communities.

Pharmacists, as evidence-based practitioners, play a huge role in educating prescribers to support them in optimal prescribing for their patients. Pharmacists educate prescribers informally on a regular basis, and they have formal roles where they lead in individual educational outreach.

Pharmacists also have established roles in integrated primary care teams, and they collaborate every day with their colleagues to ensure optimal prescribing of antibiotics through direct and individual feedback on prescribing. This practice has met with much success in the hospital environment.

CPhA participates in the interdisciplinary AMS Canada steering committee and the Canadian Roundtable on AMS. We have demonstrated leadership in increasing the awareness and importance of antimicrobial stewardship for all pharmacists in Canada. We are engaged in continuing to shape the significant role of pharmacists as part of the team in the fight against AMR.

Pharmacists are doing a lot, but we want to do more and we could be doing more to help as primary care providers. We need to have the authority to act to make a more impactful difference. Our skills, scope, and access have enabled us to improve outcomes in chronic disease, and evidence is now building in other areas.

We also need enabling tools to be even more effective antimicrobial stewards. It doesn't make sense to me that a 32-year-old woman in New Brunswick can be treated by a pharmacist for a simple urinary tract infection, but a similar patient in Ontario can't and might have to wait longer to access treatment.

We recommend action in four specific areas. First, and most critically, we recommend that all jurisdictions, including the federal government as a provider of health services, promote harmonization of pharmacists' expanded scope of practice and associated remuneration for these services across the country. This should include prescribing for minor ailments, as well as therapeutic substitution of antibiotics.

Second, the implementation of a fully integrated drug information system and electronic health record in every province and territory would ensure that pharmacists have access to the information they need, such as patients' medication profiles and culture and sensitivity reports, to help us care for patients and work more effectively with our colleagues to ensure safe and effective antibiotic use.

Third, the Canadian Pharmacists Association, through our work with the AMS steering committee, supports the development of national prescribing guidelines. We also commit to leading the development of knowledge mobilization tools and mentorship networks for pharmacists, to ensure they are armed with the most current knowledge and skills to act as antimicrobial stewards in the interests of public safety.

Finally, we recommend that all antibiotic prescriptions include the indication for the medication—why the medication was prescribed to that patient—on the prescription. This information would help us promote optimal and safe antibiotic use, ensuring that the patient receives the correct drug, the correct dose, and the correct duration of therapy for that particular indication.

Every interaction I have with a patient or a prescriber is an opportunity to get my patient the right antibiotic, if needed, and an opportunity for all pharmacists to embrace their role as antimicrobial stewards. We need to continue to work together to solve this problem.

Pharmacists are committed to being a major part of the solution in this shared responsibility of stewardship, and we ask for the committee's support in advancing the role of the pharmacist as antimicrobial steward, as described today.

Thank you very much.

The Chair: Thank you very much.

Now we go to Dr. Michael Routledge from the Royal College of Physicians and Surgeons, for 10 minutes.

• (1130)

Dr. Michael Routledge (Medical Officer of Health, Southern Health, Regional Health Authority, Royal College of Physicians and Surgeons of Canada): Thank you, Mr. Chair, and thank you to the committee for examining this very important topic. I'm here on behalf of the Royal College of Physicians and Surgeons of Canada, as a Royal College specialist in public health and preventative medicine. The Royal College does not currently have an official position on antimicrobial resistance but fully supports ongoing efforts to address AMR and has asked me to provide my perspective as a specialist physician in public health.

I won't reiterate all that you've already heard on the background with respect to how important a topic this is both in Canada and around the world. I'm going to focus on two specific aspects. One is that, historically, AMR has been underaddressed relative to its potential impacts. Two, going forward, it will be important to continue to support and strengthen the national processes that have been created to ensure AMR is effectively addressed across the country.

Advancing the AMR agenda can be difficult, because even though it is an extremely important and impactful public population health issue, it is one that is slow moving and doesn't tend to grab headlines. You've already heard a couple of witnesses talk about the idea that it's slow moving and referred to often as a slow-moving tsunami. It's easily pushed to the corner of the desk to make way for the urgent health issues of the day.

If AMR can be positioned, going forward, as the critically important issue that it is, and if the national and regional structures that are working on this can continue to be supported and strengthened, we will be able to fully utilize all the knowledge and resources that exist in a way that supports this work across all of Canada.

The recent inclusion by Accreditation Canada of a required organizational practice on antimicrobial stewardship is an excellent example of how embedding AMR into the health care system structures can help advance the agenda. In the regional health authority where I work, we have recently partnered with the National Collaborating Centre for Infectious Diseases to develop a pilot project that looks at, among other aspects, supporting health care provider practice and education for the public. This work is being done to meet the new Accreditation Canada ROP, or required organizational practices, in part, and our hope is to continue to grow this work in all aspects of antimicrobial stewardship.

Canada has, and has had in the past, many examples of local pockets of excellent work on antimicrobial resistance, the Do Bugs Need Drugs? program in B.C. and Alberta being one example. What has primarily been lacking is a robust structure that can coordinate, disseminate, and support these leading practices across all health care organizations and professionals in Canada. The creation over the past few years of the 2014 federal framework and the current FPT steering process, combined with the efforts of organizations like HealthCareCAN and the NCCID, have positioned Canada well to take the necessary next steps.

The key going forward will be to ensure these processes are supported and monitored in order to ensure that antimicrobial stewardship is receiving the attention and work it warrants across the country.

Again, I would like to thank the committee for examining this topic, and for inviting the Royal College of Physicians and Surgeons to take part.

The Chair: Thank you very much. Now we'll go to our first round of questions. These are seven-minute rounds.

Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Chair.

Thank you, all the presenters. It was great testimony.

My first question is to Ms. Dattani. A 2015 publication of "The Translator", your organization's health policy publication, said, "The overall goal of antibiotic stewardship is to maximize patient outcomes while minimizing the unintended consequences of antibiotic use." It is also noted that pharmacists can be an important partner in preventing the spread of AMR.

Can you explain a little more the role of pharmacists in this process? How can the role be more effective on AMR?

Ms. Shelita Dattani: Thanks for your question.

As I alluded to in my comments, pharmacists are currently engaging in lots of different opportunities, whether it's counselling patients, public health and health promotion, or discussions during immunizations. Pharmacists can definitely have a more impactful role if they're able to actually intervene in patients' therapy, adapt prescriptions, adapt durations of therapy, and prescribe for simple, uncomplicated types of infections.

This is happening in a couple of provinces, but is not consistent throughout the country. It doesn't completely make sense to me, when I have the same knowledge, skills, and judgment as my

colleagues in New Brunswick or Alberta, that they are able to exercise this and act as antimicrobial stewards while I can't. Consideration of that—harmonizing practices across the country to enable pharmacists to practise to that expanded scope—is a key solution.

Ms. Sonia Sidhu: Dr. Morris, many AMR reports have emphasized the need for increased support for research and development for new antimicrobial therapies. In your view, what type of research needs to be funded in order to address antimicrobial resistance, both in Canada and globally?

Dr. Andrew Morris: Thank you for your question; it's a loaded one.

If we look at the basic elements of research, I think it has to start with an understanding of our current state. We don't really have a very good understanding of our current state in terms of antimicrobial resistance or in terms of antimicrobial use. I think the first efforts would have to be foundational efforts toward ensuring that we have good data.

Changing how we use antibiotics is a complicated task. It's change management. It's akin to having our whole population live a healthy lifestyle. I'm sure you can imagine how difficult that is. It's very similar to trying to get us to use antimicrobials wisely. It requires behavioural change techniques, psychology, infrastructure, and making it easier to do the right thing. All of those things are difficult. At this point in time, I would say that globally, we don't really have a very good understanding of how to do that.

Additionally, because you thankfully emphasized the global issues as well as the local issues, there is a marked difference in needs between high-income countries and low- and middle-income countries. The disparities include access to effective medications, regulation of the medications, and resistance problems.

What I think may be useful in Canada may not apply to other jurisdictions, and vice versa. I'm very supportive of efforts to address global needs and issues. I think those are absolutely necessary. It is unclear to me at this point in time whether those will translate to Canadian processes and needs for research.

● (1135)

Ms. Sonia Sidhu: Thank you.

I want to ask the nurses association something.

In your view, how knowledgeable are Canadians regarding AMR? Also, I heard testimony that \$1 billion is being spent on antibiotics in Canada. Last week we heard that 95% of that use is in the community. Do you think we need more public awareness? How can we do more public awareness? What kinds of steps need to be taken?

Ms. Karey Shuhendler: Thank you for your question.

I don't think Canadians are as knowledgeable as they could be about the issues of antimicrobial resistance. Dr. Morris made a comparison to the current opioid crisis. There aren't a lot of public faces to deaths attributed to antibiotic-resistant organisms and the impact those have. There is definitely some room there for Canadians to be more informed.

That comes with stewardship programs like Do Bugs Need Drugs? or Choosing Wisely Canada, which have a public facing component of the campaign. We as health care providers and as a government have a responsibility to provide education to the public so that the public is not presenting to a physician or nurse practitioner or pharmacist to obtain medication that is not warranted. They need to be aware that the absence of a prescription doesn't mean substandard care, but that maybe you're getting better care because your clinician is taking time to do a full assessment to provide the education.

The public needs to be on board with that. They need to be well informed. Campaigns like Do Bugs Need Drugs? and Choosing Wisely Canada have been effective in providing the information that more is not always better, but more definitely needs to be done.

Ms. Yoshiko Nakamachi (Antimicrobial Resistance Nursing Expert, Canadian Nurses Association): I think also the public awareness campaign and the education need to start for those at a very young age. I think we need to be talking to the kindergarten children, all the way up through the continuum, and through the lifespan and educating individuals and creating that awareness. It doesn't just start with the parent or the elderly person when they're faced with having to deal with a particular infection, but it's the way we socialize our next generation and the generation right now as well. Again, it's about public awareness campaigns that target the spectrum and the range of individuals in our society.

Ms. Sonia Sidhu: Dr. Morris, chicken farming is a major economic contributor. We heard earlier this week about antimicrobial resistance in agriculture. Can you describe the risks that the medical and non-medical use of antibiotics can pose to human health?

Dr. Andrew Morris: Some of that is a bit outside the scope of my area of expertise. What I can tell you is that many of the antimicrobials that are used for animals are not of medical interest or significance. With regard to those that are, almost certainly a reduction in use of those antimicrobials will benefit the Canadians population.

We know for sure and there is no question whatsoever that when resistance develops in animals, especially in agriculture but also in companion animals, that resistance eventually makes its way into the human ecosystem as well. That's why I think everyone here and anyone who works in the field has always felt that a one health approach to antimicrobial stewardship and resistance is the best way to tackle it.

• (1140)

The Chair: Time's up.

Ms. Harder, go ahead for seven minutes.

Ms. Rachael Harder (Lethbridge, CPC): That's awesome.

My first question is for Mr. Morris.

We're talking about antimicrobial resistance. Let's say we do nothing, theoretically, and we leave things as they are and things continue to progress. Paint a picture of what this is going to look like 50 years from now.

Dr. Andrew Morris: I'm not sure I'd be too good at predicting 50 years from now. I'm not sure it's even necessary to go 50 years ahead.

Several countries right now don't have availability of certain antibiotics due to production problems. Australia recently had a problem with piperacillin-tazobactam, which is an important broad-spectrum antibiotic.

Having a drug unavailable because of production is, in many ways, similar to not being able to use it because of drug resistance. What ends up happening is that you reach for other drugs, you result in harm, and you get side effects. If you can't use any antibiotics, which is what will almost certainly happen if we do nothing, the complication rates.... For example, I have an artificial hip. The risk of me getting that infected at the time of surgery was somewhere around 1%. Thankfully I got antibiotics at the time of surgery so the risk went from 5% down to 1%.

If we can't use antibiotics for a simple surgery like that, then one in 20 people who are getting hips, rather than one in 100 people who are getting hips, are going to get infections. For Caesarean sections, it's the same thing. The risks are even higher. It's the same with abdominal surgeries. The list goes on.

For transplantation medicine, for solid organ transplantation, the backbone of that is antimicrobials. It requires a very broad team to be involved, but the backbone involves antimicrobials. Supportive care for cancer chemotherapy absolutely requires antimicrobials. If you have leukemia and you're receiving chemotherapy, you are almost certainly going to require broad-spectrum antimicrobials for weeks.

No cancer chemotherapy, no transplantation, no high-risk surgeries, and that's not 50 years from now; that's 15 to 20 years from now at best.

Ms. Rachael Harder: Thank you. It's very helpful for us to have that actually painted out really practically.

In 2015, the Auditor General came out with "Report 1—Antimicrobial Resistance". It noted that another six guidelines were needed, moving forward, as I understand it, for specific antimicrobial-resistant infections. But, as I believe you noted in your testimony, that was put on hold. Those guidelines actually haven't been further developed.

Can you comment on that?

Dr. Andrew Morris: I can't specifically. I don't recall the particular guidelines that were mentioned in the Auditor General's report.

Antimicrobial stewardship as an initiative has involved partnership with several people here along with the Public Health Agency of Canada. There was anticipated funding to a variety of organizations and groups around Canada, and that amount was actually really modest. We're talking about a total of probably less than a couple of million dollars at most. All of that has been suspended, to my knowledge.

We basically have the Public Health Agency of Canada saying that antimicrobial stewardship is important but it's not important enough, and that they're going to have to put further funding on hold, and that's going to prevent us from moving forward.

If we're talking about guidelines, I think many experts in the field—and I consider myself one of them—recognize that in order to discuss appropriateness of antibiotic use, you need to have a benchmark. The benchmark in most countries that have done this has been to develop guidelines. We have no national guidelines on how to use antibiotics.

To do that would require Herculean effort and considerable time and cost. It's almost certainly necessary, but I don't see it happening in the next five to six years.

• (1145)

Ms. Rachael Harder: Okay. Thank you.

Right now we're in the middle of putting together a pan-Canadian approach. It's supposed to be coming out imminently, we're told. I'm wondering if your organizations have been engaged in this process of creating this framework.

Maybe we'll just work across the panel. What has your engagement been?

Ms. Yoshiko Nakamachi: My engagement has been as a member of that task force on stewardship. There were four task forces, for each of the four pillars: infection prevention and control, surveillance, research and innovation, and stewardship. I was engaged in developing and putting together a report for what success would look like, and also what stewardship activities would need to take place in order to move forward.

Again, it's a framework, but specific actions for success moving forward were indicated. The report that our group, the stewardship task force, developed was merged with the reports from the other three task forces to create the pan-Canadian framework document that you're referring to.

Ms. Rachael Harder: Thank you.

Ms. Karey Shuhendler: Yoshi sat on the committee, and so did a colleague of mine. Josette Roussel was a member of the CNA. We did have additional representation from CNA on that committee as well. We did provide input on the infection prevention and control draft framework, as well, which was merged into the complete report.

Ms. Rachael Harder: Mr. Routledge, were you involved at all?

Dr. Michael Routledge: I don't think we were involved at all.

Ms. Rachael Harder: Ms. Dattani.

Ms. Shelita Dattani: We were not involved on this particular committee. We are a part of the AMS national steering committee.

Ms. Rachael Harder: Mr. Morris.

Dr. Andrew Morris: AMMI Canada has had some involvement with it, as I, personally, have. I wear several hats. One of those hats is obviously representing AMMI Canada, but I also represent the Sinai Health System and University Health Network program. In my capacity of wearing all those hats, I've been involved. AMMI has also been involved with the other task forces.

The Chair: Time is up.

Mr. Davies.

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

Thank you to all the witnesses for being here.

Dr. Morris, you've given us, I think, a very trenchant description of the seriousness of the problem. On a scale of one to ten, ten being very serious and one being that we don't need to care about it at all, how serious is the issue of antimicrobial and antibacterial resistance in Canada today?

Dr. Andrew Morris: Thank you for the question.

I'm not sure how to put a number on it. I'm not somebody who really wants to scare. It's very important. If we're talking about how much it will affect Canadians' lives in the next five to 10 years, I'm going to say it's going to substantially and almost certainly affect Canadians' lives if we don't do anything. In fact, it may involve Canadians' lives despite us doing something about it, because the world is small. We have to deal with antimicrobial resistance to not only those bacteria that we breed in Canada, but also to those that we import here through travel, immigration, agriculture, trade, etc.

Mr. Don Davies: Would you agree with me that the problem is serious and requires urgent attention?

Dr. Andrew Morris: It requires urgent attention.

Mr. Don Davies: Thank you.

Now I want to try to get a handle on the causes.

Can anybody on the panel tell me what the contributors to antimicrobial resistance are, and list them in the order of priority for me?

Dr. Andrew Morris: I'll start.

The number one cause of antimicrobial resistance is antimicrobial use. Antimicrobials are the "A" in AMR. One could argue that the only cause of antimicrobial resistance is antimicrobial use.

Without trying to be too pedagogical about it, I will just say that as I was teaching students yesterday, I said that if we went just outside and went to the lawn, there was a war being waged between bacteria and fungi. The fungi are defending themselves against the bacteria with antibiotics that they produce. The bacteria are defending themselves from the fungi by developing resistance mechanisms. That war rages on in many places.

We, as humans, don't tend to have many fungi in or on us, but we have many bacteria. When we do get exposed to fungi or the antibiotics that they produce, we use them to kill bacteria that cause us problems. Some of the resistance occurs out in the environment and comes to us, but there really is no major cause of antimicrobial resistance other than bacteria being exposed to antibiotics.

• (1150)

Mr. Don Davies: If I can focus you, Dr. Morris, I'm going to zero in on the human causes of antimicrobial resistance. Can you give me an idea as to the relative contribution to antimicrobial resistance of, perhaps, over-prescription to patients versus the contribution of antimicrobial use in veterinary medicine and agriculture?

Dr. Andrew Morris: I'm not sure we know that. I think there have been several smoking guns over time related to certain strains of drug-resistant bacteria, but there is a lot of overlap.

In Canada, for medically significant antimicrobial resistance in humans, almost certainly more than half of that resistance is related to human use. It can be very difficult, because there's so much interface between, for example, the food we ingest and resistance that we may acquire from the food that it makes it very difficult to pinpoint it to one. This is why, again, I think all of us believe that taking a one health approach is really important, because there isn't just one problem that needs to be fixed.

Mr. Don Davies: I see.

Dr. Routledge, could you explain how the prescribing practices of physicians and the prescribing practices regarding antimicrobials are regulated, reported, or enforced?

Dr. Michael Routledge: I'll take a stab at that, and maybe Andrew can add something as well.

I would say that the prescribing per se isn't regulated. Overall practice is what would be regulated. Certain types of prescriptions would be more regulated. For example, narcotic prescriptions have a regulation to them. Antibiotics don't have those, generally speaking. I think probably where you're going is that the prescribing of antibiotics generally speaking isn't specifically regulated.

Mr. Don Davies: Do you think there's a need to have stricter antimicrobial prescribing practices? I'm curious about the prevalence of this issue, say, in the training of physicians. After all, it's physicians who are prescribing the antimicrobials. Should it be stricter? Is there enough education of physicians on the subject?

Dr. Michael Routledge: On that last question, I think the answer is no, and it's not just physicians. As we've talked about, this is really all health care providers, because not only is the prescribing expanding to go beyond physicians to include nurses and pharmacists, but also we work as teams. All the health care professionals involved in the teams need to have that education.

Should there be more regulation? I would say no. I think there are other ways you can get at this without regulating it. It's an option, but I would say there are other ways we can do it that are probably more effective.

If I could just add something, you asked the question about agricultural versus human use. I would basically echo what Andrew said, but I think both really are important. Depending on what you read, some sources will say that it's agricultural use predominantly;

others will say human use is the major cause. The reality is that both are significantly important, so it really is important and critical to address both spheres.

Mr. Don Davies: Ms. Dattani and Ms. Nakamachi, is there enough education among the nursing profession and pharmacists about antimicrobial resistance?

Ms. Shelita Dattani: Maybe I'll answer first. I think there's always need for education, both intra-professional and interprofessional. Education in and of itself can be a relatively passive strategy. It's important, but it needs to be coupled with other things. What's worked really well—and Andrew can speak to this, I know—in the hospital care environment is direct audit and feedback, and physicians' prescribing practices being compared with those of their peers.

I've lived and worked in that scenario as well, and I feel that it has met with quite a bit of success. I think the way we educate and how we actively provide feedback becomes a little bit more salient than sort of more passive group education, but it's important.

• (1155)

Ms. Yoshiko Nakamachi: Thank you for the question. I would have to agree that education alone is possibly not enough. It has to be coupled with other types of interventions or knowledge translation.

To answer your question with regard to whether there is enough education for these health care professionals, I agree that it's a team sport, but up until now, nurses have been largely ignored and underutilized and have not received the same type of training. Again, I think there definitely needs to be more training for both pharmacists and physicians, but for nurses there is almost no training available when they're doing their nursing degrees.

Also in the hospital setting and the community setting, there aren't educational programs for nursing or targeted at nursing, because the triggers for antimicrobial use or monitoring are very different for nursing than they are for pharmacists and physicians. The educational programs need to be specific to the profession. It's a team sport, and we all play different positions on the team.

The Chair: Time's up.

Mr. Kang.

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): Thank you, Mr. Chair.

My questions are for Shelita Dattani.

The overuse or misuse of antimicrobials has arisen from different causes, including over-prescribing by doctors, failure by patients to complete a course of antibiotics as prescribed, and the medical and non-medical use of antibiotics. According to Antimicrobial Stewardship Canada's brief, about 23 million antimicrobial prescriptions are written every year. The brief says that 30% to 50% of the prescriptions are not necessary. It is costing lots of money, \$70 million to \$80 million. It boggles my mind when I see this happening.

You said your organization has done something, like education. Have you worked with other health care providers like the CMA or the Royal College of Physicians and Surgeons of Canada? What steps have you taken to correct this unnecessary over-prescribing?

Ms. Shelita Dattani: Thank you very much for your question. You are right that there are a lot of unnecessary prescriptions, particularly—I always think of that 30%—in community environments where practitioners are often a little more siloed and aren't in formal microbial stewardship programs.

CPhA has taken some good leadership over the last year in increasing the awareness to its own profession, particularly in primary care, where there hasn't been a lot of education, and even more so for primary care pharmacists, regarding how they can step up.

I agree with you on the next step. To echo my colleagues, Yoshiko and others, this is a team sport, and without collaboration we can't solve this, so it's very important to have a very strong interprofessional focus on education, on practice, on prescribing, on patient education, and on all elements of antimicrobial stewardship. That's definitely something we will be looking at this coming year, starting with education.

Mr. Darshan Singh Kang: What steps has your organization taken to support patient compliance with respect to the use of antibiotics as prescribed?

Ms. Shelita Dattani: In terms of our organization specifically, as I mentioned earlier, we participate and relay the messages of campaigns, like Do Bugs Need Drugs? and Choosing Wisely to help.

As I mentioned previously, I think we all feel that patients don't have the understanding they should have about the risks and unintended consequences of antibiotics versus the benefits and the notion of them as a cure-all. As an organization, we specifically have some Choosing Wisely recommendations coming out. We also endorse recommendations from other organizations and societies that are more specific to antibiotics, and we espouse those in relaying messages to patients every day.

Part of our ongoing educational campaign and knowledge translation to members of our profession is going to be to arm them with those tools so they can use an evidence-based approach to encourage the public and patients to also be stewards. We're all stewards. Andrew is a steward. I'm a steward. Members of the public need to be stewards. This is really a public safety issue, so we need to arm them with the right information, and we're doing that.

• (1200)

The Chair: Dr. Morris, you wanted to add something?

Dr. Andrew Morris: I just want to point out that it's a common misconception that not completing a course of antibiotics leads to drug resistance. That's been thrown around for decades. It's not correct. It may put people at risk of relapse of their infections, but as I pointed out before, the only thing that leads to drug resistance is ongoing exposure to antibiotics. I just wanted to make that clear.

Mr. Darshan Singh Kang: My next question is for you.

The upfront cost here is maybe 30% to 50% of \$70 million to \$80 million for unnecessary prescriptions. These are prescribed, and patients take them. Are there any side effects? What kind of cost is there to society for this?

Dr. Andrew Morris: Sorry, who's that question directed to?

Mr. Darshan Singh Kang: You can answer it and—

Ms. Shelita Dattani: I'll start.

In terms of costs, I think Andrew is going to be able to answer this question much more effectively than I am, but I'll give you an example.

The second most common reason for a drug-related adverse event when a patient presents to an emergency department is an antibiotic-related adverse event. The costs—and the health system costs associated with that—are significant. Unintended consequences, such as *Clostridium difficile*, the superinfection that can arise with overuse of antibiotics, have significant costs.

I can't necessarily put numbers to those costs. I don't have those off the top of my head. I'm sure Andrew can expand on this, but those are two examples that I'd offer you.

Mr. Darshan Singh Kang: Dr. Morris.

Dr. Andrew Morris: As Shelita mentioned, a paper that came out just this week showed that one out of every five patients who receives antibiotics gets adverse effects that are directly related to the antibiotic. Those adverse effects lead to increased lengths of stay in hospitalized patients. For a patient, one extra day of hospitalization alone trumps another 10 or even 100 patients receiving antibiotics on any one day. If we're talking about one out of every five, you can just imagine what that impact is on the health care system.

Out in the community, it's much more difficult to quantify the costs associated with it. We know, for example, that about 20% of human antibiotic prescribing in the community is done by dentists. Most of those are unnecessary. Many of those result in adverse effects that are mostly mild gastrointestinal effects, but in using back-of-the-napkin math, we can figure out that there are probably dozens of deaths in Canada each year from patients receiving unnecessary antibiotics for dental procedures.

The costs are in lives.

Mr. Darshan Singh Kang: Thank you.

According to the World Bank—

The Chair: Very quickly.

Mr. Darshan Singh Kang: Very quickly? Okay.

They are talking about trillions of dollars if we don't do anything about this microbial resistance. To what extent has your organization been engaged in the development of the federal government's pan-Canadian framework on this?

Dr. Andrew Morris: I chair the AMMI Canada antimicrobial stewardship and resistance committee. Over the past year, that committee has developed and disseminated tools primarily targeting long-term care facilities initially, around unnecessary antibiotics—

Mr. Darshan Singh Kang: What are the critical components in the framework?

Dr. Andrew Morris: I'm sorry. I'm misunderstanding the question.

Mr. Darshan Singh Kang: What are the critical components in the framework to address this?

Dr. Andrew Morris: To address the costs and the threats?

Mr. Darshan Singh Kang: The microbial...

Dr. Andrew Morris: I think the 10 action points of Canada's antimicrobial stewardship are all key. I was heavily involved. I chaired that group. It had broad consultation, research prior to that, and follow-up after that. We meet regularly. That pan-Canadian group of experts laid out very clearly 10 things that needed to be done with, I'm going to say, a relatively modest investment, in comparison to the anticipated costs if we don't act.

•(1205)

The Chair: Okay. You're done.

Mr. Darshan Singh Kang: Thank you.

The Chair: We're starting our five-minute sessions now.

Dr. Carrie, you have five minutes.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Mr. Chair.

I'll tell you that the more I read about this, I get worried. It seems that humankind may have, what, only 70 or 80 years where these drugs are effective? They have been game-changers.

I want to thank all of you, because it is a huge issue and it's not getting the attention it needs. It's an issue not only here on the ground in Canada, but internationally. It affects everything from livestock to feedstocks. I'm going to try to ask you some uncomfortable questions. I hope you don't mind, but you're the experts and you're here.

Doug mentioned a really good point with our last round of witnesses, which is that sometimes in the practice of medicine or health care on the ground, people get into their prescribing habits and things along those lines.

Dr. Morris, I think you brought up the opioid crisis. Here at the federal level last year we brought up the topic. We got experts in and all that stuff, and what has happened in Canada? This past year, there were more prescriptions instead of fewer. You're here. This is a federal committee, and what we want to hear from you is what the federal government should do. Should the federal government be using more of a heavy stick here? I think it was David Cameron who called "on the governments of the richest countries" of the world "to mandate now that by 2020, all antibiotic prescriptions will need to be

informed by up-to-date surveillance information and a rapid diagnostic test wherever one exists."

You mentioned the dentists, who aren't here to defend their prescribing practice, but we have three organizations here that are hugely important and have a role to play. What would you tell these guys sitting next to you about what they should be doing? Also, what should the government be doing? How far should they be going with the carrot-and-the-stick type of thing?

Dr. Andrew Morris: Thank you for the question. I'll try to be as brief as possible.

On the CARSS, Canadian Antimicrobial Resistance Surveillance System, report, I apologize to the people who have done very hard work on it, but it relies on data of very poor quality, and I don't trust it for the paper that it's printed on. We have no current understanding of antimicrobial use in Canada and in most provinces. It's the same problem that we've had with opioids. If you can't properly, reliably, and validly identify the problem, it's very difficult to act on it. A basis has to reside with good data.

Yoshi and I are colleagues, and we've learned over time that leadership is absolutely important in this. I'm going to say that the national leadership around antimicrobial resistance has been largely deafening in its silence. We don't really have a national voice on antimicrobial resistance and stewardship. AMMI Canada likes to see itself as a partner with some of these other organizations here in taking a leadership role, but we need a more centralized role. It hasn't come from the federal organizations. For most provincial organizations as well, we haven't seen that.

Almost certainly what needs to be coupled with leadership and sound data is money that supports an infrastructure to share information across the country, to act on a plan that has been very carefully thought out, and to then be able to provide on a broad level and then at a very granular level the issues around antimicrobial use and antimicrobial resistance. They are intertwined; they are not separate. They are very closely related, and they include both humans and animals and other aspects of our "one health" ecosystem.

When we don't have significant money being put into the pot, we don't have leadership, we don't have reliable data, and we aren't going to go anywhere without those foundations.

Mr. Colin Carrie: I appreciate the answer. I appreciate your trying to be brief, but I think I'm almost over four minutes out of my five minutes with that comment. There are huge challenges in Canada and with the provincial jurisdictions.

You talk about leadership. Have you brought this to the Council of the Federation? I'll give you one word: Quebec. With your national association, when you get provinces and territories together, sometimes there seems to be some protection of who should be doing what. Have you brought this to the Council of the Federation to see if you can get agreement across provinces and territories? That seems to be a block.

•(1210)

Dr. Andrew Morris: We have not. I'm not familiar with that council. I apologize.

Mr. Colin Carrie: Okay. I think some of the other organizations are, but I see that my time is up.

Mr. Chair, I know that afterwards we're going to be talking about the potential cannabis bill. I hope we can do that publicly instead of in camera.

The Chair: Okay.

Now we go to Dr. Eyolfson.

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

I'm sorry if I'm hard to understand. I had to explain this on Tuesday: I have laryngitis. As I explained to the last panel, I'm not on antibiotics.

Voices: Oh, oh!

Mr. Doug Eyolfson: Ms. Dattani, thank you. You made my job very difficult today because I had a number of questions for you and you answered them in your presentation before I got a chance to ask them.

Dr. Routledge, as we discussed at the door, I'm an emergency physician. I trained in the Royal College program about 20 years ago. Through the program, we went through pretty much every specialty in medicine: general surgery, intensive care, internal medicine, and orthopaedics, which is where we learned that the heart is the muscle that pumps the Ancef to the bones. Given that every specialty I was in, with the exception of psychiatry, prescribed antibiotics, would it be a reasonable thing to make sure that units on antibiotic resistance be included in the guidance of the curriculum of all the different residency programs?

Dr. Michael Routledge: The quick answer is yes, but I'm going to divert your question if that's okay, because we've talked a lot about education. There are all kinds of things we've talked about in terms of analogies to the opioid crisis. Climate change is actually another interesting analogy.

What's missing right now is that while providers have heard this for a long time, and I think all physicians—and I'm going to say other health care professionals too—know about antimicrobial resistance and know they should be following guidelines, I personally think the challenge is that our health care organizations in this country haven't taken this on. In terms of national leadership, Accreditation Canada has really moved that forward by introducing this ROP, which means that health care CEOs across this country have to care about this now, whereas before they didn't.

Until we actually create structures whereby the health care organizations in which health care workers work are seeing this as a priority and developing it, it's tough to get providers to say that they should care about this. If you just put it on education, it's not going to happen. Andrew used the word “environment”, I think, at some point in his comments. You have to create the environment. You must have the health care organizations making it easy for providers to follow the appropriate guidelines. We need to have the education, but until the health care organizations take this on...and that needs to come from the bottom up and top down.

Mr. Doug Eyolfson: Thank you.

Dr. Morris, I was very interested in what you said about the lack of a role in failure to complete a course of antibiotics, because that was one of the things I was taught in residency: you should use antibiotics like azithromycin, which have a shorter course, because they're more likely to complete, and less resistance, and how we find out.... As I say, that's news to me that it's not actually an issue. That was very interesting.

My challenge is that my whole career was in the emergency department. The last eight years were in an inner-city emergency department. There was a lot of poverty. A large proportion of my patients did not have a primary care physician. All their primary care was through the emergency department, so we saw things that we had to prescribe antibiotics for, and follow-up was a tremendous challenge.

How would you advise the emergency medicine community? They're doing a greater share of primary care. What advice would you give to that field in follow-up and their antimicrobial stewardship?

Dr. Andrew Morris: Thank you for the question.

I do a fair amount of work with emergency physicians in my LHIN in Ontario, my local health integration network. It's really an issue of knowledge translation. Emergency physicians are front-line physicians. As you mentioned, increasingly they play a role in primary care. It's not so much preventative care, but primary care. I don't see it as much different from any other aspect of the health care system in terms of wise use of antimicrobials. We need to put systems in place. We need to have tools available to the prescribers so they make the right decisions, and so it's easy to make the right decisions and very difficult to make the wrong decisions.

• (1215)

Mr. Doug Eyolfson: That's true. We were taught that “emergency medicine is the art of making correct decisions with insufficient information”, so that's good to know.

Thank you.

The Chair: Thank you very much.

Now we go to Mr. Webber.

Mr. Len Webber: Thank you.

The first thing I want to talk about is climate change. Something I read in an article a while back was in regard to the recession of our glacial waters and our pack ice and such. What's coming up, apparently, are ancient organisms that are getting into our lakes, organisms that we're not familiar with.

I don't know whether to ask you about this, Dr. Morris, or you, Dr. Routledge, as to whether or not you have the college studying or researching this. Have you heard of any research going on with respect to preparing for these ancient organisms that will perhaps one day hit us as a population?

Dr. Andrew Morris: I haven't. I'm sorry.

Mr. Len Webber: All right. I was hoping to ask that in the last session, but of course I didn't have enough time. I just thought I'd throw that out there.

I want to share the story of an experience I had. Most politicians meet people and shake hands daily. About three years ago, after shaking hands with about 200 people at an event, I went home with a sore wrist. I woke up at three in the morning with a hand that was about two times as large. I went to emergency, where they basically cut my hand open. They took blood samples, and of course I had an infection, through a tiny little cut I had in my finger, that apparently I got from shaking hands. This led to many levels of antibiotics. I spent a week in the hospital. They were talking about perhaps amputation, which scared the heck out of me as well. I went through two months of carrying an antibiotic pump on my side.

That was all because of shaking hands and getting infected. I warn everyone to continually wash their hands. I know that's been part of the education program.

By the way, Mr. Chair, I don't even know if we have any of that handwash stuff in here. We need to get it. Can we work on that?

The Chair: Absolutely.

A voice: It's out in the hall.

Mr. Len Webber: Okay.

I've become very paranoid. I don't touch doorknobs anymore. When I do shake a hand, I think about wanting to quickly go to the washroom to.... No, I'm just kidding.

Ms. Sidhu brought up awareness in Canada about such things, and about how we can easily become infected. I hope that is very much a part of the Nurses Association.... I have to say that the nurses were incredibly wonderful at the Foothills hospital in Calgary. I can't say enough about them in treating my episode. I do believe it is incredibly important that we teach kids at a young age to wash their hands, to be aware not to put their hands in their mouths and their eyes. I just wanted to share that, and I hope that is part of your mandate for the future as well.

Do you have any comments on that at all, about where you are with education?

No, it doesn't look like it. Okay.

Boy, this is difficult, trying to get—

Ms. Karey Shuhendler: Thank you for sharing that story. It highlights some of the challenges that people experience first-hand with resistant organisms or infections.

In our brief we recommended, as an example, the scaling up of community-based antimicrobial stewardship programs. We used the example of Do Bugs Need Drugs? I'm not sure if the committee is familiar with the program, but as Yoshi mentioned, it targets across the lifespan. It does teaching in schools about washing your hands, about when you need vaccinations or not, or when you don't need medicine if you're sick. There are those programs that are available that CNA absolutely believes in.

Much of Do Bugs Need Drugs? is a collaborative effort. A colleague of ours who presented last week, Kim Dreher, is a nurse, and she said that at the outset of delivering those programs they were nurse-delivered in communities. Now they're also delivered by med students and pharmacy students. It's a very collaborative effort.

Really, the shift to public education has to start with health care providers. Of course, being from the Nurses Association, I'll just highlight that sometimes nurses are the only health care providers in a community or in a setting. We appreciate the opportunity to respond to that, because we are sometimes people's first point of contact with the health care system. We have a role here in making sure that people are aware in terms of preventing infections but also judiciously using antibiotics.

• (1220)

The Chair: Thank you, Mr. Webber, for the excellent questions. Your time is up.

Mr. Oliver.

Mr. John Oliver (Oakville, Lib.): Thank you.

Thanks very much for being here today and for your testimony.

I got a bit confused listening to this. I had always thought that AMR was about a pathogen that for various reasons had become resistant, and about the difficulty of treating at-risk people. I kind of heard in the testimony, particularly from Mr. Morris, that AMR is about ongoing exposure to antibiotics. Are there situations where individuals become resistant? Is it more about a pathogen that's resistant that then becomes transmitted, or is it about individuals becoming more AMR because of their antibiotic use?

Dr. Andrew Morris: Thank you for that question and allowing me to clarify. People in and of themselves don't become resistant. It's somewhat of a metaphysical kind of question, because to some degree we're not only what we traditionally think of as ourselves but also the organisms that are in and on us. We each have our own bacterial fingerprint.

The person doesn't become resistant. It's the pathogens, that for many people don't cause any problems, that develop resistance and may be passed on from person to person, or animal to person, or the other way around. When those take hold and cause disease, that's when we have a clinical problem. People in and of themselves don't characteristically develop resistance; it's the bacteria, the pathogen, that can be transferred onward.

Mr. John Oliver: Okay. Thanks for that.

There were two recommendations, I think, from the Canadian Nurses Association, and I heard a number of strategies from the pharmacists group.

The committee will be issuing a report. Do you have any other recommendations? We know that a new national pan-Canadian framework is coming out. There are the 10 recommendations in the action plan. Is there anything else that you recommend we flag to the minister and to the government to expedite or improve our response to AMR?

Dr. Andrew Morris: I've tried to be clear as much as possible. Most of those things are covered in the framework. I would not underemphasize the issue of leadership. In the U.K., Dame Sally Davies—

Mr. John Oliver: Just to be clear, how would that leadership manifest itself? Are you looking for a national point person on this?

Dr. Andrew Morris: I think that's probably what you need, to have somebody in Ottawa or anywhere else. You need that point person who is responsible, has ownership, has the mandate to ensure that the right thing is done, and who is also the vocal point.

I would just emphasize that in the U.K., their chief medical officer of health, Dr. Davies, issued a letter to all family physicians who were outliers in terms of their antimicrobial prescribing. It was actually a trial. Half got the letter, half didn't. There was a substantial reduction in antibiotic prescribing after she sent the letter, and it was because she was a recognizable point person. I think it would be very difficult for anyone in Canada to identify....

I know that this committee has been interested in opioids. My guess is that you'd be hard pressed to find a national leader or point person for opioids. I would say the same thing for antimicrobial resistance, which is, I would argue, more complex, because it goes outside of humans. There are so many other reasons why it's probably even more complex, and the opioids problem is already very, very complex.

You really do need a point person who will see the big picture and oversee and lead something like this.

•(1225)

Mr. John Oliver: Does anyone else have any thoughts on recommendations or on that leadership point?

Dr. Michael Routledge: I would echo the leadership point.

I'll make another comment along the lines of what's been said before on this topic. I just want to take you back. In 2004 we had SARS, and we developed a lot of plans for SARS. Then SARS went away and we stopped thinking about it. Then a pandemic hit. People started pulling their SARS plans off the shelves. Nobody was really ready, because we'd kind of forgotten about it. It's easy to forget about, because all kinds of other things come up. We need to replace hips and knees and we need to get MRIs done and things like that.

We need to have ongoing eyes on this. I spent four years as the chief public health officer in Manitoba. I sat at the FPT tables. It's really critical for those tables, and in this case for the FPT steering committee, to have.... We talked about the Council of the Federation. The health ministers table and the deputy ministers tables need to be demanding action from that group and seeing it on a regular basis.

Mr. John Oliver: Thank you.

The Chair: Mr. Davies, you have three minutes.

Mr. Don Davies: Thank you.

Ms. Nakamachi, I didn't really give you an opportunity to answer the question about urgency. As a representative of front-line health care workers, nurses working in the wards of hospitals, can you give this committee a general sense of how important the issue of antimicrobial resistance is? Are you seeing patients to whom you're giving broad-spectrum antibiotics and then all of a sudden it's not working on them?

Ms. Yoshiko Nakamachi: Yes, absolutely. I know the question was what will our health care system look like 50 years from now,

but we're already seeing patients who have multi drug-resistant organisms experiencing that.

Again, our most vulnerable population is the leukemia patients or transplant patients. When people think of vulnerable populations, they think of the very young and the very old, but that's not necessarily the case, so there certainly is an urgency.

With respect to nursing and the role that nursing can play, again, antimicrobial stewardship interventions can occur anywhere along the lifespan, from prenatal all the way to end of life. Nurses have a role and play a role in health care from prenatal to the end of life. Again, with the urgency here, there is definitely a role for nursing to play.

Mr. Don Davies: Thank you.

Dr. Morris, do you have an idea of the mortality rate? Canadians no doubt are dying from the inability to treat infections because of antimicrobial resistance. Is anybody tracking this?

Dr. Andrew Morris: No.

Mr. Don Davies: No? You talked about surveillance. You mentioned three reports issued in 13 years. You talked about the government eliminating or suspending money for the upcoming year in surveillance. You quoted the Auditor General—

Dr. Andrew Morris: Sorry, that was for stewardship.

Mr. Don Davies: It was for stewardship, sorry.

You referred to the AG report, I think from 2015, which said that Health Canada had failed to meet its key responsibilities.

I have two questions. Has this changed yet in the last year since the AG report? What resources are needed to increase surveillance and create the good data that we need to get a thorough handle on this issue?

Dr. Andrew Morris: I think things have somewhat changed in terms of intense change. We have this federal framework and there's been work in terms of developing policy and having FPT partners signing off on this. I consider that a move forward in terms of addressing AMR.

There's been increasing money to CIHR to address a variety of different research priorities that CIHR has around AMR. I think there's been some progress there, including through their participation in the joint programmatic initiative on AMR, which is an international effort.

In terms of what's needed for understanding and having better data, a better repository of information, it's going to have to be almost certainly something that's staged in nature, and there will have to be a ramp-up. To my mind, you start off with understanding existing datasets and validating them to make sure that what they're supposedly saying they really are saying. A lot of the data in these is actually from proprietary information that the Canadian government doesn't even own. On top of that, you need to start with probably the easiest systems to put in place, which would be understanding use in hospitals, and then you need to expand that to long-term care and then community practices in provinces. You need standards.

Shelita has already alluded to the need to have national standards for how statistics on antibiotics and resistance are collected and reported. Initial investment for that is probably going to require several million dollars, but over time it is going to be considerably larger than that because many provinces currently don't have that infrastructure. Some do; some provinces have an ability to track antimicrobial use in a much more granular way than most other provinces can, so we're talking about tens of millions of dollars.

•(1230)

The Chair: Time is up, and that completes our time for our witnesses.

I want to thank you all for your very impressive testimony.

I have a confession to make. When this committee first came together, we decided on the priority issues to deal with, and one of those issues was antimicrobial immunity. I didn't know what they were talking about, so that's how far we have to go with public awareness.

Ms. Nakamachi, you were talking about a kindergarten. Well, you need to educate the other end of the spectrum as well. That's how far we have to go, but this process will help. Things move very incrementally here, but they do work. The system does work, and you are part of it. I want to thank you very much for your contributions, because they were very effective.

That's it.

Dr. Carrie.

Mr. Colin Carrie: Just before you close the meeting, I notice that we will be going in camera, but as everybody is aware, the cannabis bill has been referred to our committee.

I would say this is one of the most important bills we've had the opportunity to review. There's a lot of interest in it, and I was just wondering if you could explain why we would be going in camera for that explanation and discussion.

The Chair: I can....

Mr. Davies.

Mr. Don Davies: I'd like to second that. In fact, I pulled the blues and the committee Hansard from Wednesday, February 17, 2016, when we first discussed in this committee when it would be appropriate to go in camera or not. Members may remember that I had a motion that would explicitly say that committee business was conducted in public at this committee other than when we were considering draft reports or when it was necessary to discuss

witnesses' evidence or names in a free and open way, or for confidential or personnel matters. I said that the consideration of committee business should always be public.

At that time, Mr. Chair, you very generously reached out and stated your very clear position that this would be the general thrust of this committee. Now, obviously, the general description of the dates and subject of the study on the cannabis bill doesn't fall within any of those parameters where we discussed it would be appropriate to go in camera. I notice that there are members of the media here. The cannabis legislation was a major policy during the last federal election, and there should be no reason whatsoever that the public can't listen to our different views on how we choose to engage public input into this committee.

Of course, once we get into the study and discuss the witnesses and who they may be, that of course appropriately would be in camera, but at this point, it's not appropriate to go in camera, and I would ask that this portion of the meeting be public.

The Chair: Before we go any further, the issue is that my agenda for our committee business is the AMR budget first, then the cannabis study, and then the Lyme letter, if we ever get to it. The budget is always done in camera. I was supposed to do it last week, but I let the committee get ahead of me, and we didn't do the budget. We have to do it this week or the witnesses may not get—

Mr. Don Davies: Mr. Chair, that would be fine if we go in camera for that portion, but I'm suggesting and supporting Dr. Carrie—

The Chair: Mr. Oliver.

Mr. John Oliver: I think it's a really important bill, and I think a lot of Canadians are interested in how the committee handles the bill. I would certainly recommend that we stay open for this piece. As I said, it's important, and Canadians want to see how we're handling it and how the committee will be discussing the bill. It's a major change in many parts of Canadian practice and norms, so I'd recommend as well that we stay open.

The Chair: You're all fighting for the same thing here. It's perfect.

Mr. Don Davies: Mr. Chairman, we're in violent agreement.

The Chair: Ms. Harder.

Ms. Rachael Harder: It brings me some solace that Mr. Oliver agrees with this. It is certainly very important that this stay public. The cannabis bill is very important to the Canadian public, and they do need to understand how this committee plans on studying this legislation.

•(1235)

The Chair: I think it's going to be a very interesting and educational session. I'm looking forward to it myself, but we have to come up with the right plan to make sure we meet the requirements of Parliament.

Dr. Carrie, you're on the list.

Mr. Colin Carrie: I was going to suggest that we deal with this part first, if we can, and then go in camera for the budget.

The Chair: I'd suggest that we even do the budget publicly. It's just for this committee meeting or this subject we're talking about. There are no big secrets or anything. We could probably do that.

Mr. Webber, you're next on the list.

Mr. Len Webber: I'll ask for some clarification of a comment you made about when we are in camera. You mentioned the letter for Lyme and said "if we ever get to it". Are you referring to if we get to preparing one at all?

The Chair: One is prepared. You should have a copy of it now.

Mr. Len Webber: I have not seen that letter. All right. The clarification is clear. Thank you.

The Chair: All right. I need a motion to not go in camera, because it's on the agenda. Does somebody want to move that? Dr. Eyolfson.

(Motion agreed to [See *Minutes of Proceedings*])

The Chair: We're going to suspend. Thank you very much for sitting through that. We're going to suspend for just a minute while we clear the decks, and then we'll go into committee business.

• (1235) _____ (Pause) _____

• (1235)

The Chair: Order.

All members have a copy of the budget for our antimicrobial resistance study. Is there any debate? If there's no debate, could I have a motion to pass the budget?

Mr. Davies.

Mr. Don Davies: Mr. Chair, I move that we adopt the budget as proposed.

The Chair: Is there any debate?

(Motion agreed to)

The Chair: The motion is carried. The budget is carried. There you go.

Now, on Bill C-45, are we ever lucky to get this brought to our committee. It's going to be interesting. It's very important. It's a huge change in the way we do things. We're all aware of how important it is, and we're all aware of a time frame, so who would like to start?

Mr. Oliver.

• (1240)

Mr. John Oliver: I have circulated a motion. I'm going to make a couple of changes to it as we go forward, but I will quickly explain this.

This is a complex bill. It represents a fairly substantive change in the norms of how we view marijuana and the use of marijuana in Canada. I think it's really important. I've been talking to a number of committee members, and there is significant interest in hearing from many witnesses and hearing testimony from different sides of different issues. If we handle it as we would normally handle our committee business, we could be hearing witnesses for months.

It is important that we review the bill, that we give it full and open consideration, and that we hear from witnesses but also that in a timely fashion we return it to the House so it can go through the rest of the processes that need to be done.

The motion is looking at a way that will allow the committee in a very focused way to hear from a number of witnesses and to work quite diligently at this review to make sure we have a substantive number of witnesses who come forward and that we organize ourselves to hear the witnesses in a way that makes sense so that we can hear countering views around some of the more controversial issues. It's also a way for us to give full consideration and to hear from a number of witnesses to start.

Nothing in this motion is intended to say there will be no more witnesses. Nothing is intended to restrict the witnesses. We can still continue after this, but the motion proposes that we have one week of dedicated time, as a committee, on this topic to hear witnesses, that we would meet for four days, and that we would organize our work so that we can get at least 72 witnesses in that week around different topics. I'll review the topics in a second.

As I said, once that week is done, if we then determine that other witnesses are needed, or if that leads us to other areas that we should consider, then nothing limits us having more witnesses and nothing in here limits the time we have yet, because we do have to do a clause-by-clause review of the bill, and we'll need time to hear from the witnesses, to synthesize what we've heard, and then to do the clause-by-clause review and to give thought to that.

Nothing in this bill is restricting that. This is really just about setting up a time for the committee to have a focused four-day period to hear from a number of witnesses around some themes as a way to kick-start our work on this very important, very significant bill for Canadians. As I said, it doesn't limit further witnesses and it doesn't put time restrictions on the clause-by-clause study.

In addition to that, I am proposing that we come back a week early and that we meet before the House sits and that we work for the week of Monday, September 11 to Thursday, September 14, which is the four days before the House sits. Again, it gives us a focused effort. We're not being interrupted by votes in the House and other routines that often interfere with witness testimony. We can have four very focused, very good days getting through witnesses on some of the important topics that we know we have before us.

It's also at a time, because the House is not sitting, when we may actually have additional media time and additional public interest in this, because the normal things that happen in Parliament aren't happening in that week. I know it's going to put a burden on members to come back from their constituencies and the work they're doing with constituents for that four-day period, but I do believe it will give us a really good start on hearing and understanding all perspectives around Bill C-45.

I am proposing:

That this Committee meet from Monday, September 11, 2017, to Thursday, September 14, 2017, inclusively for the purpose of the consideration of Bill C-45

I'll cut out some of the verbiage. You have it in front of you. I'm changing it to "and, that each party send their lists of prioritized"—rather than "proposed". The clerk has suggested that it's easier for them if you prioritize the lists—

—witnesses for the purposes of this study...and that the Chair be empowered to coordinate the witnesses, to a maximum of 72 witnesses, the resources, and scheduling necessary to complete this task in accordance with the following guidelines:

● (1245)

I'm proposing that we take those four days and break them into two four-hour blocks per day, with nine witnesses per four-hour block, and that we do two rounds of our normal questioning as well. It would be nine witnesses, and for questions it would be two rounds of seven minutes; five minutes; and then three minutes.

I propose that we organize the blocks into a number of categories. The first would be federal, provincial, and territorial responsibilities, which would include retail presentations. Revenue questions would be included in there.

The second category would be justice and public safety. We would hear from the police, RCMP, and others. If there were questions around the impact on organized crime, that would be a natural place to include witnesses around that topic.

Then we would look at other jurisdictions' experiences. Others have gone down this road, and what were the lessons learned? If there were international considerations, this would be a point in time to also build in international issues around compliance with other jurisdictions.

The next category would be the household cultivation of plants, which is a very common question that I've heard from others. It would also give us a chance to hear from landlords and tenants, and if there are rental issues on that topic.

Another category would be the age for legal possession and the impact on young Canadians. There's also prevention, treatment, low-risk use versus high-risk use, and health risks.

We would also look at workplace safety. There is a corresponding piece of legislation to this one, which is dealing with motor vehicles and heavy equipment. Otherwise, what's the impact on workplaces? Do we have appropriate detection? It would be a place to build in how we can detect and understand if somebody in the workplace is under the influence.

Then there's the impact on indigenous communities. That would be the eighth topic we would deal with.

The witnesses would be proportional to our committee. It would be five from the Liberals, three from the Conservatives, and one from the NDP. Generally on these topics we have a high degree of overlap anyway in our witnesses, but I think that would be the normal method the clerk would use to assign witnesses.

I'm changing number three. It currently says that witnesses should be directed to prepare oral remarks of five minutes. I think we can do 10 minutes. We normally do 10 minutes with four witnesses. We usually have about 20 minutes free in a two-hour block, so if we go to nine witnesses in a four-hour block, it's tight. We'll have about a 10-minute window in each four-hour block. The reason I was

thinking of five minutes was really for us, just so that we have breaks. The four hours is not that intensive, and we make sure to ask for written submissions to augment the five minutes, but given that our committee practice has been 10 minutes, then we probably should stay at that 10-minute mark.

The second change I had in here is that witnesses be invited to submit their written statements prior to August 18, which would give time for the translation.

Is that correct?

Okay, sorry. It was my misunderstanding. In number three we will go back to 10 minutes, but we don't need to change the timing of the written statements on that one.

Number four really isn't about this week. I'm trying to get this week organized for us, because the House should be rising shortly and I want to make sure we have a good, robust week of study of the bill. Four is really about setting deadlines for others. Normally the committee sets a cut-off for when we receive submissions. I think we can deal with that when we come back and have a cut-off set. I'll leave it in for now and we can have discussions. In paragraph four, the chair would set a deadline of August 18 for written submissions regarding Bill C-45.

Paragraph five proposes that the Minister of Health, the Minister of Justice, and the Minister of Public Safety be invited to appear before the committee on Thursday, September 14. It would give us, at the end of that week, a chance to hear from the ministers involved in this, if they're available. It also proposes that they be given 10 minutes for remarks.

Again, I'm not trying to restrict other witnesses and I'm not trying to force us to clause-by-clause. I'm just trying to set up a very robust week of intensive work for us so that we can hear from a number of witnesses on some of the key topic areas that have been controversial in our debates in the House so that we can get a good start to our review of this bill.

Thank you.

● (1250)

The Chair: I think there's a lot of good work there, and a good road map.

Ms. Harder.

Ms. Rachael Harder: Mr. Oliver, overall, this looks good. I only have a few concerns.

One, I would like to see at the beginning a specific time frame set for each day so that the times when you're hoping to meet are actually in the motion. For example, are you hoping to meet from 8:30 a.m. to 12:30 p.m., or are you hoping to meet from 6:00 a.m. to 10:00 a.m.? What are the time frames that we're working with each day? I'd like that set out here. Would you be willing to amend that?

The other thing is the four-hour block. Listening to the same nine witnesses for four hours can be a long period of time. I wonder if that is going to serve us in the best way possible. Perhaps we could consider breaking that into two two-hour blocks instead, with even a short 15-minute break in between. It wouldn't add a ton of time to our day, but I think maybe we'd be able to digest the information a little more easily. Again, could we make a friendly amendment there?

With regard to the topics at hand, one of the things I'm wondering about—and you can probably clarify this for me—is that I don't see a place for municipalities. I've heard from all of mine, and they're very concerned about this legislation and about the time frame for by-laws that they have to put in place. I wonder, again, if we could add another friendly amendment to the list.

Last, I don't see a place, or it's not obvious to me, where we would fit in things like packaging and labelling. Maybe you could clarify that for me as well.

The Chair: Mr. Davies.

Mr. Don Davies: Mr. Chair, at the outset I just want to reinforce that this legislation changes over a century of legal, social, and cultural rules, mores, and law in our country. As I said earlier, this is a flagship bill that was a major campaign plank for the Liberals in the last election, and I think we all agree that it is of great interest to many Canadians and stakeholders. I don't think it's an exaggeration —

The Chair: And us.

Mr. Don Davies: And us, and of course everybody, parliamentarians and the people we represent.

I don't think it's an exaggeration to say that billions of dollars are at stake, not only on the medicinal front but also as we move towards Canadians accessing in a legal way the sale of recreational or adult-use marijuana.

I'm pleased to see that this motion is written in a way that leaves it open-ended whether or not we have more meetings. I was concerned that if we limited this testimony to four straight days of public input, effectively in the summer before Parliament sits again, it could convey to the general public that this committee and this Parliament are looking to restrict public input.

I would point out that this part of the legislative process, this committee phase, is the only phase when members of the public and stakeholders have the opportunity to come before Parliament and express their comments on the proposed legislation.

I know that there was some consultation during the McLellan task force, and the government had a website, but that was prior to any legislative framework being designed, and that is what we have before us.

I know there are going to be a lot of people from a lot of different perspectives who will want to have their input into this legislation. Frankly, I think we will benefit from that input, so I'm very glad. I want to put on the record now that I'm almost certain that from of those four days, as always happens with every study we undertake, we'll learn a lot. Issues will arise that we haven't anticipated, although I think that John has done a good job in setting out some of

the major areas. I don't think it's quite there yet, as I'll say in a moment, but it's largely there.

Certainly, there will be other issues raised by the testimony that will prompt further questions from us, and so the opportunity to have further days of testimony, later in September, is important. I will say right now that I think it will be necessary.

There are a couple of more things.

In terms of the structure of this, I don't think the subject matter is complete. I agree with Rachael on this. I had indicated originally when I saw this list that packaging and marketing were not included here, and packaging is a part of this bill. There's a very strong cleavage between those who want to see—in fact, I think the bill does speak of it—a plain-packaging regimen, as opposed to those who would like it marketed more like alcohol, where there's branding and lifestyle advertizing, particularly for the recreational aspect. That's going to be a very important part of this bill, and I think every one of us has had meetings with people who want to get in on the commercial sale and are intensely interested in how they'll be able to market this product. That should definitely be added as a subject.

Another critical subject that's missing is edibles. I don't know if the bill deals with this. I think it's a very important part of safety to determine whether these drugs will be available in gummy bear form or brownies, or any other aspect of that. I think that this committee—

• (1255)

The Chair: This going to be exciting.

Mr. Don Davies: —should really be looking at edibles as a subject. I think we should look at whether or not it should be covered.

Finally, medicinal marijuana is not indicated in this list, which, I think, is a subject.

I have to say there are a couple of things in here that I'm not sure warrant complete separation as subjects. For instance, workplace safety I'm not sure is a subject on its own. I think that will be touched on by adding these other subjects. I'm a little confused as to why indigenous communities would be segregated out on cannabis. I'm not sure that there's any particular aspect of this bill that has a unique application to indigenous communities.

I have a final couple of housekeeping matters.

I would rather not have one witness allocated per subject. Rather, let's just divide up the witnesses by our percentage and let each party determine where they would like to call their preponderance of witnesses. There might be a subject here for which I'm perfectly comfortable with the government's witnesses and on which I don't feel I have a witness who could add anything, but there may be another subject for which I would like to have two instead of one. I would propose that friendly amendment.

John, you mentioned something about there being at least 72 witnesses. This motion talks about the chairman scheduling a maximum of 72 witnesses. I understand that you're referring to just these four days, but I want to be clear that we're talking about 72 witnesses for these four days.

Finally, within those 72 witnesses, the last item proposes that the three ministers appear before this committee. If they have 10 minutes each, that's going to take up a significant part. I would even propose that, perhaps, we sit on the Friday, as well, and have the fifth day. Maybe that could be limited just to the ministers, as an example.

One of the difficulties I had when I thought this would be only the four straight days was that it would not give us any time, really, to digest the evidence, or if you hear something, to research and inquire among other people to get different perspectives. That's another reason I'm really going to be pressing the committee hard to have a day or several days of testimony after this, so that after these four intense days or five intense days, we have a chance to reflect on what we have heard and maybe even hone some further testimony. We've seen that in the pharmacare study, Mr. Chair. As there is testimony, it's an organic process, and we decide to call yet other witnesses to go down paths that maybe we didn't anticipate at the beginning.

Finally, on paragraph 1(i), I'm not sure federal-provincial responsibilities warrant a topic on their own. We're a federal committee, and we are going to be looking at the federal issues on this, I think.

I guess what I'm saying is, with regard to those paragraphs (i) to (viii), although I think it's a very good first proposal, I'm already seeing that some of them should be dropped and others should be added. Either we can do that now or maybe we can leave this a little bit flexible in some way. I don't know how the committee wants to have it or how my colleagues feel about that. Otherwise, I would propose that we drop paragraphs (i), (vii), and (viii), and replace them with packaging, edibles, and medicinal marijuana. I don't want to limit any particular category. If members feel there should be other areas, then I think we should add them.

Those are my preliminary comments at this point.

• (1300)

The Chair: Thank you very much.

Dr. Carrie.

Mr. Colin Carrie: Thank you very much, Mr. Chair.

First, I want to say that it's interesting to get the opportunity to study this bill. Also, I appreciate the opportunity to discuss this motion, because I know that in the provinces and territories there are a lot of questions, and the timeline of July 1 is being seen as an extremely tight timeline. I'll disagree with Don a bit about the provinces and territories. I believe they have a lot of questions, and I think it's incumbent on this committee to actually allow them to ask those questions and get prompt answers, because the timeline to make such a substantial change that's happening here is really going to be tight for them.

I have a couple of recommendations that will perhaps move this forward a little more quickly.

I agree with Don about the "maximum of 72 witnesses".

I appreciate John's talking about these topics, but I don't think those topics actually have to be in the motion. I think they could be hashed out in a planning meeting.

Don brought up some really good points about edibles and things along those lines. I know that it may not be intended to be restrictive—you may not have intended it—but I think it does come across that way. As we discuss it, if there are stakeholders who want to come in and talk about a few different things....

I'd also like to point my colleagues towards the really good job the analysts have done with the legislative summary, the pre-release unedited portion of it. I think they've done a great job, and of course they're non-partisan. It is available upon request for public use, so this could get out and people could take a look at it.

They did a good job of talking about topical organization. They talked about the prohibitions, the obligations offences, criminal activities, other prohibitions, promotion, and what Don said, which was about packaging and labelling, displays, selling and distributing, obligations, and a miscellaneous category, which was, did they have ticketable offences...? We've heard the debates in the House. Even though this is the federal legislation, there are some options for provinces and territories and how this is understood in terms of licences, permits, general authorizations, ministerial orders, a cannabis tracking system, and inspections, which is huge, as we're finding out with the medical marijuana, and which maybe we are not doing as well as we can. What are the options for this for the general public? As well, they talk about the disposition of seized things, administrative monetary penalties, transitional provisions in the related Controlled Drugs and Substances Act and the Criminal Code, and coming into force. Coming into force is going to be huge here.

I think the analysts have done a really good job.

From my standpoint, to move the motion forward, I like your amended your motion that now includes the word "prioritized" lists. I would even take out "a maximum of 72 witnesses". Depending on if we're doing those two-hour blocks, we might be able to leave it up to the analysts and clerk as they start booking. We might be able to be flexible there. Also, I would take out what I see could be interpreted as overly prescriptive, which is point 1 of your motion.

I would also suggest that in point 5, where you say "the Minister of Health, the Minister of Justice, and the Minister of Public Safety be invited to appear before the Committee" on the Thursday, I would like to see them here on the Monday, as the first witnesses. It's their bill. I would like to see what tone they want to have reflected in it. It may help us when questioning some of the witnesses going forward. At the end of the day, these are the guys. It's their bill. They wrote it. Things are going to be put forth to us that are really important for interpretation, so it would give us a bit of an idea on our line of questioning.

I'd also ask.... I was curious to note that, as Don said, it does stop on September 14. I was just wondering, is there is something happening on the 15th that we might not be able to...?

Voices: Oh, oh!

Mr. Colin Carrie: There have been all kinds of leaks about what may or may not happen. I'm glad you're not saying that this is it, because as we learn a little more as a committee, I think we're definitely going to need to study it.

In that light as well, on point 4 that “the Chair set the deadline for written submissions”, I think we can just take that out. At the end of the day, witnesses may hear what other witnesses say, and if this goes on a little longer, I wouldn't want to see them not being able to submit something in a timely manner, something that we couldn't take into account.

• (1305)

With those changes, I think we could almost, from my standpoint, move the motion and get it passed today.

The Chair: Mr. Oliver.

Mr. John Oliver: An assumption has been made here. I won't deal with all the questions, but the motion puts this responsibility for booking us onto the chair and the clerk. I know there are a number of different issues, a number of different things, and that's why I thought giving more specific direction to them was.... If we don't have one in there, then we're all going to submit a whole bunch of witnesses, and we're going to have a sort of potpourri of witnesses during that week, and it's going to be harder for us to process what they're speaking to and what the issues are.

An alternative would be that the steering committee meet, and instead of putting the mandate to the.... First of all, if we are going to have 72 witnesses in a four-day period and then the ministers coming in on the fifth day if we run that day, I do think we need to organize the witnesses in a way that gives us sort of pros and cons around a topic. I just wasn't sure that that would happen without us giving clear direction to the clerk in advance. That's why I proposed this. It wasn't meant to be restrictive; it was meant to be guidance on how we want to do our work as a committee.

We have have a steering committee that has often met to set who the witnesses will be, the timing of them, and how to organize the blocks. We could do that sometime in that first week of August. I did check and we have to sit together. It means coming back. We have to come together, then, as a subcommittee in that first week of August to meet with the clerk and the chair and to set our committee list. I'm quite prepared. I can't speak for my counterpart, but I think it's a really important topic. I'm prepared to put my time into it during the time when we're in the constituency.

The reason I did four-hour blocks is that it allows us to have nine witnesses. If we go back to our traditional two-hour blocks, which is what Ms. Harder had asked about, then we lose that extra witness. We'd have to go back to our normal four and four and four and four, so we'd lose eight witnesses if we stayed with eight-hour days. That's why I'm suggesting the four-hour block. It puts more on us to take on that additional witness time, but it gets more witnesses in front of us.

I think workplace safety and indigenous communities are both important topics. The indigenous communities, I'm sure, will have some views and perspectives on this, but perhaps not for four hours. Maybe we would do a two-hour block on workplace safety and a two-hour block on labelling and packaging, and we would do a two-hour block on indigenous communities and a two-hour block on another topic. We could do edibles, or—

The Chair: Just for clarification, could you just tell us what might happen on Monday, September 11?

Mr. John Oliver: On Monday, September 11, the goal would be to have nine witnesses for the first four-hour block starting whenever the chair decides—

The Chair: Do you mean all at the same table at the same time?

Mr. John Oliver: —at 8:30. It could be however you want to structure the four-hour block.

The Chair: We could do it with half the witnesses for two hours, take a little break and then half the witnesses for the other.

Mr. John Oliver: Sure, but nine doesn't divide that easily.

The Chair: No, it doesn't.

Mr. John Oliver: It would be however you want to set the four-hour block up for us, Mr. Chair. And then we would break for an hour, and then have nine witnesses on justice and public safety.

The Chair: I think that would be more effective. Also, I think the meeting should have a theme, because the subjects are so different. We should have a theme for every meeting, I think.

Mr. John Oliver: Just as a friendly amendment to the motion, we can go to Friday, September 15, and we can move the ministers to September 15. I don't believe, based on what I understand to be the cabinet schedule, they would be available on the Monday, Tuesday, or Wednesday of that week. I don't know that's the case, but I would like to stay with some organization of the witnesses so we don't just get a potpourri of witnesses for the full week. I think we just won't know which way we are looking if we don't organize it thematically.

I'm happy to split workplace safety with packaging and labelling, and happy to split indigenous communities with....

Is it edibles that you wanted in, Don?

• (1310)

Mr. Don Davies: I think it should it be.

Mr. John Oliver: That would be the topic? So that would be four and four and four and four. Those would be two-hour sessions each on seven. It would be workplace safety and labelling and packaging, and then indigenous communities would be the last block split with edibles.

The Chair: Just a second.

Mr. Davies is next after Mr. Oliver.

Mr. John Oliver: The fifth one changes, so that we would ask them to be available on September 15, if possible. Those would be the amendments that I've heard.

The Chair: Mr. Davies.

Mr. Don Davies: Thanks, Mr. Chair.

I know there were 90 witnesses proposed for Bill C-46 and I think that almost that number have been approved to come before committee for Bill C-46, which is a much smaller bill. Bill C-46 deals only with the impaired driving provisions. This is the major legislation that has major chunks.

To put it in perspective, this proposal as it stands, if we left it at 72, would actually have fewer witnesses testifying at this committee than would the bill on impaired driving, if that's what the justice committee ultimately decides on.

I'm really concerned that we be able to have really fulsome stakeholder and public input on this bill. The number 72 sounds like a large number, but it actually isn't when you consider all of the different subject areas and how much public interest there is in this. In terms of the commercial interest in this, there are dozens and dozens and dozens of organizations and companies and legal representatives that really want to have their say on this, so I want to really emphasize that.

From my point of view, after waiting a hundred years for this legalization, allowing the public to comment on legislation for only four days is not doing justice to this bill.

The Chair: I just want to comment.

I don't agree with you on that. I think the only way we're going to get more witnesses is if we do it this way. If we don't do it this way and we spread it out all through the fall, we won't get nearly as many witnesses.

Mr. Don Davies: I was going to say that I think we're all mindful of the Prime Minister's declared objective to have this legislation in place for July 1, 2018. I, for one, and the New Democrats are generally supportive of this legislation and generally we want to facilitate that passage, particularly since, as everybody on this committee knows, we've been raising the spectre of Canadians being convicted of possession each and every day that this legislation doesn't get passed, so we want it passed soon.

But let's be honest: we're talking about a date that is over a year from now, and even if we start in the first week of September, that gives us an entire parliamentary calendar year to get this legislation through committee and third reading in the House and then the Senate.

I know that the Senate has had a sudden renaissance of independence in it that is creating some interesting challenges for the government, but nevertheless, I think that if we have other days scheduled in September, and this committee has finished its clause-by-clause by the first few weeks of October, it would go back to the House for third reading by, say, October 15, and that would give a month or six weeks in the House, and this bill could be over in the Senate by December 1.

There is absolutely no urgency. There is no reason to rush this bill when we can get it to the Senate by the end of this year, or even into January, giving the Senate five months to pass it.

I just want to really emphasize that. From my point of view and the New Democrats' point of view, we want to make sure there is fulsome opportunity for public and stakeholder input into this bill, and that's what we'll be urging as we consider this study. I don't think four days, with 72 witnesses, is going to do it.

•(1315)

The Chair: I just got a message from the analyst. She has suggested that they put together a work plan for the steering committee. The problem with doing that is that the steering

committee then has to report back to the committee of the whole before it's all....

Mr. Colin Carrie: That was my point.

The Chair: I think if we can make the decision here, it would be much better.

Dr. Carrie.

Mr. Colin Carrie: That was one of the things I was going to bring up. At the end of the day, the witness list and everything has to be brought back to the full committee. If John is saying that we'd have to get together in August, then so be it, but I'll go back to my argument about having point 1 in here. The way it's written with the four-hour blocks, it's very prescriptive.

Again, the analysts put forward this very good legislative summary. Depending on the interest and the availability, perhaps we could give them a bit of leeway to come up with a work plan for us over that period of time. They've heard the topics, and I think we've heard just around the table here more than eight topics that maybe could be congealed into even a smaller number of topics—or themes, as the chair brought up, which I think is a good idea.

Point 1 in the motion takes away some of the flexibility. That's all I'm thinking here. As this gets out, we may want to spend a bit of extra time here or there, or there may be other topics that we weren't thinking of.

I do want to go back to the dates. I sincerely thank John for putting them forward. I don't know how this date of Thursday, September 14, came through the channels of the government, but I'm worried about having the ministers on the 15th. We know that this place is filled with rumours, and the rumours are out there now. If the government does decide to prorogue, one of the dates they suggested was the 15th, which means that the ministers wouldn't be here.

I would like to have the ministers here sooner than later, particularly the Minister of Justice, if we can only get one. I don't know what the cabinet members' schedules will be like, but this is a priority of the government. I think if the government wants to get this through, they know the cabinet schedule way in advance, and I know that cabinets can sometimes be a bit flexible too. It's important to have at least the Minister of Justice here before that date of September 14, because none of us here really knows what will happen on the 15th.

The Chair: Ms. Harder.

Ms. Rachael Harder: Thank you very much.

I certainly echo what my colleague Colin Carrie just said.

Mr. Oliver, I would like to come back to the time frame. It seems now that perhaps you are amenable to breaking up those four-hour sections into two sections of two hours at the discretion of the chair, which I think is really wise, if for no other reason than the physical space involved. Just to get nine witnesses in here is rather a task, so that's worth considering.

In addition to that, though, I would like to look at this list. One of the things that isn't included here is international impact, and that is certainly worth considering. What will it be like to cross the border into the United States by vehicle? What about the different agreements we've signed with other countries that will be impacted by this law coming into effect? None of those things are being considered within this existing list.

I come back to my point that it doesn't seem that you're friendly, Mr. Oliver, to adjusting and including municipalities. At the end of the day, this legislation doesn't stay with the federal government. It gets moved over to the provinces and the municipalities. It will become their responsibility to implement and come up with policies and bylaws and laws around it. It's very important to hear from municipalities with regard to this piece.

Those are my suggested amendments.

The Chair: Mr. Kang.

Mr. Darshan Singh Kang: Thank you, Mr. Chair.

I think when we are doing two-hour blocks, instead of having four witnesses we could probably have six witnesses. That would give 12 witnesses in four-hour blocks. Then we could hear 24 witnesses in one day, if bringing in more witnesses is a concern.

How many did we have here today?

• (1320)

The Chair: We had four groups. One group had two people.

Mr. Darshan Singh Kang: Yes.

Those are my comments. Thank you.

The Chair: Mr. Oliver.

Mr. John Oliver: Thank you for the feedback on the motion. I appreciate it.

I want to reiterate that my goal here was to get all of us to agree that we would be back a week earlier to dedicate ourselves to long days of studying Bill C-45 to get us started on the bill. I would be happy if we could move the week to run from September 11 to September 15, which gives us two additional four-hour blocks. We could invite the ministers to come the following week and have them come to a session the week after. I do think that we need to hear from the ministers at some point in the process.

That would give us an additional two four-hour blocks on the Friday, and we could add—

I'm sorry, Ms. Harder, but I didn't mention municipalities because they are a construct of the provinces, so they really fall under provincial/territorial jurisdiction. We could have a municipality in that block.

There's a question I want to come back to. We are either going to mandate the chair and the clerks to do this and come back to what they've set up, and stay with these general themes, plus the ones that have been added, such as labelling and packaging, edibles—

Mr. Don Davies: Medicinal.

Mr. John Oliver: —and medicinal.

An hon. member: International treaties.

Mr. John Oliver: For the international treaties, I had them lumped in with other jurisdictions' experiences, but that's fine. That's international treaties, so there are those three additional topics.

Then we would try to submit our witnesses in a way that is organized around those topics and, if you have a general witness, which of those categories you think they would be best suited to so they can be slotted in, so that we give.... We're all going to be submitting massive lists and they need some structure. We can do it this way or we can reconvene the subcommittee and mandate it to set up the meetings. We would do that sometime in that first week of August, but in neither one are we going to be requiring a report back to the committee. If it's the chair and the analysts, or if it's a subcommittee, we have to mandate them today so that we can come to work that week and get working on this bill for Canadians.

I'm happy either way on this motion. Can we be a bit loose on order? Do you want to do a subcommittee or do you want to have the chair and analysts setting up the meeting?

The Chair: I'd just like to throw this out here. It's a big test, but if you feel comfortable with me, the clerk, and the analysts taking in all the information we have here today, we'll put together a proposal or a schedule based on Mr. Oliver's motion, with all of the things considered, because I think they're all good arguments. On the municipal one, I agree with Ms. Harder, because those who have approached me the most are the municipalities. If you trust us to do this, based on that, we could be done with it, and we'll get it back to everybody.

I believe—I've been here long enough to know—that we have to do this right. If we do this wrong, this side will pay a bigger price than that side, but we have to do it right. I'll do the best I can to do it right and to make sure that we hear all the witnesses we need to hear. There's no limit on the witnesses. We're not limited to six, or to 72, or to anything else, but if you let this end of the table put something together, based on what everybody has said, and pass Mr. Oliver's motion with flexibility, then we'll work it out.

All in favour?

Voices: Oh, oh!

The Chair: Mr. Davies.

Mr. Don Davies: Thank you.

I'm almost there, Mr. Chair. I agree with almost everything except when you say "pass Mr. Oliver's motion", because I'm not exactly sure how the motion would read right now, given the discussion. I'm happy to have you, the analysts, and the clerk work out what you heard, if you can incorporate the sort of flexibility that John has expressed. What I would almost suggest is that we rewrite the motion now. Not right this minute, I mean, but I think we could rewrite the motion honing it now to reflect where we're going with this.

Some things I think we do have to figure out, and one is the number of witnesses, for instance. If we're calling for five eight-hour meetings, split up the way you're talking about now, it was 72 witnesses before, and adding another day would be—

Mr. John Oliver: It would be another 18.

•(1325)

Mr. Don Davies: —another 18, so you're at 90, plus the three ministers. If you're going to do that, then I would suggest that the witnesses be apportioned to the parties in proportion to the seats in the House Commons, which is 13% for us, 30% for the opposition, and whatever the balance is, 50%, or whatever, for the Liberals—that's typically the practice—and let us propose the witnesses that we have. I would suggest that we rank them. So let's say that for 13%, that would give us about 11 or 12 witnesses. I'll give you 20 witnesses and rank them so that the analysts can call them, because, as we know, some people can't come, and they will call in the order that you submit.

I propose that to free us from that sort of strict categorical thing. If I can get only one per category, then I have to really work on the categories. It sounds as though we're agreeing on the general categories here.

The Chair: That's fantastic.

Mr. Don Davies: Then let us fill those categories with witnesses as we see fit.

The Chair: Dr. Carrie.

Mr. Colin Carrie: Thank you very much, Mr. Chair.

If you do want to get something passed today, if you look at the top part of the motion, and if we put a period after “task”, and then just state what we spoke about today in regard to the timelines—I actually put in two blocks, from 8:30 to 10:30, 10:45 to 12:45, 2 to 4, 4:30 to 6:30—it would give us the breaks and a lunch for those dates.

As far as the prescriptive part here goes, I think there's going to be some continued debate on that. Maybe we could put that towards a planning committee. We are going to be around next week, I think. Maybe we can have a conversation next week, a more fulsome one, on the details. If we passed a motion that allowed us to do that, to put a prescriptive time in so we would have our dates in there, and give us a little bit of time to think about the actual prescriptive stuff, I would be happier with that.

The Chair: Dr. Eyolfson.

Mr. Doug Eyolfson: [*Inaudible—Editor*]

The Chair: Ms. Sidhu.

Ms. Sonia Sidhu: I think it's a very important bill. I agree that we should have breaks, but we would have to see how many witnesses we have. We have nine witnesses, if they fit in that. If we had half as much time for lunch, that would give more space and we could put nine witnesses in there. I'm in favour of that.

The Chair: All right. So where are we going to go? Is there something we can conclude today?

Mr. Oliver.

Mr. John Oliver: Let's soften this down. I do want to stay with the idea of themes. I've been a bit disappointed at times with having presentations on longer topics, as they seem to be a bit meandering. You hear one presentation from one person, and then three weeks later you hear a counterpoint to it. I would like to get consolidation around the themes if possible.

So if we're saying “that the Chair be empowered to coordinate the witnesses”—we're adding an extra day, so it's now September 15, and we're adding another 18 witnesses—and we could say “scheduling necessary generally in compliance with the following guidelines” rather than “in accordance”.

“Witnesses are to be organized to speak to the following...”, and I'm going to suggest we do two- or four-hour blocks. If it's easier for you to break the topic down into two-hour blocks, then it would be four people, and if it's the four-hour block, we can get nine in.

We have a fairly substantive list now. We've added municipalities. We've added labelling and packaging. We've added edibles, and we've added medical marijuana usage. If you want to have a stand-alone one on international considerations, we could have a stand-alone for that as well, because we can do these in two-hour or four-hour blocks.

I would suggest, “That witnesses for each topic generally be proportional to committee membership”. I know you always do a very good job of balancing the witnesses according to who has presented them. Perhaps you could continue to follow those general guidelines, but as Mr. Davies said, he might have two or three around one topic, but then none on others, so let's be respectful of where one of the committee members has an interest in a topic. I think that's it.

For “That the Minister of Health...be invited to appear before the Committee...”, let's just say “in the following week”, so that we can hear from the ministers after that intensive week. It mandates it, and it gets it going, but it does organize it in a structured way.

I'd be happy to move the motion with those amendments.

•(1330)

The Chair: If we move the motion, we can pass the budget for this. It helps the thing move along.

I really believe there is consensus here that we want to do this right. Nobody is trying to hide anything. Nobody is trying to avoid anything. I'd like to see us, if we can, move Mr. Oliver's motion with the flexibility. The chair will be flexible and watch and make sure that everybody's interests are addressed and we complete the study.

Yes, Dr. Carrie.

Mr. Colin Carrie: I actually agree with you. That's why I'm saying that we shouldn't rush about the themes. Let's pass the general motion. Let's allow you to come back next week. I'd be happy to sit for another two hours to just do committee business next week and iron this out, get it figured out. We want to make sure that this is the best bill we can possibly get. My concern is that if it's too prescriptive and it's in the motion, it's binding. We passed it: if we change our minds or if we get some things we want to add or move around a little bit, we can't do it. If we pass the general motion, and then we're allowed to talk about it next week...

It's pretty much that top part, with a little bit of the verbiage that you have in there, which I'd like the clerk to read back to us, if he wouldn't mind.

Mr. John Oliver: There's a motion on the floor.

Mr. Colin Carrie: Yes, but could he read it back?

Mr. Don Davies: Don't make him.

Some hon. members: Oh, oh!

The Chair: You're on the speakers list, Mr. Oliver.

Mr. John Oliver: Well, I've requested that the motion as amended be passed.

The Chair: Okay. And that's with the list that you have here?

Mr. John Oliver: Yes. I've added labelling and packaging, edibles, international considerations, medical marijuana, and municipalities.

Ms. Rachael Harder: You've added international...?

Mr. John Oliver: International considerations.

Ms. Rachael Harder: Okay.

Mr. John Oliver: We've added six topics. It can be either two-hour or four-hour blocks, depending on how many witnesses come here. There's more flexibility around which witnesses for which topic, depending on submissions, but it's generally following the committee structure.

The Chair: Dr. Eyolfson.

Mr. Doug Eyolfson: I move that the debate be now adjourned.

The Chair: No, no, you can't do that—

Mr. John Oliver: That stops the motion.

Mr. Doug Eyolfson: That stops the motion? I was stopping the debate. I thought that's what we were talking about.

The Chair: No. That was a good try.

Mr. Doug Eyolfson: I'll withdraw that.

The Chair: Okay.

Mr. Davies.

Mr. Don Davies: There is a difference between the number of witnesses in proportion to the members of the committee and in proportion to the of seats in the House of Commons. It's the difference between my getting 10% of the witnesses or 13%. The reason we get only one seat here is that 13% rounds down to one, but 13% is the difference between my having nine witnesses or 11 witnesses.

Can we do that?

Mr. John Oliver: I'll take that as an amendment.

Mr. Don Davies: Okay. Thanks.

Mr. John Oliver: I will take that as a friendly amendment so that the witnesses for each topic will be proportional to the House of Parliament percentage of seats.

Mr. Don Davies: So the percentage of seats in the House of Commons.

The Chair: Dr. Carrie.

Mr. Colin Carrie: Can I just add a friendly amendment here? After the part that talks about the committee meeting from Monday, September 11, 2017, to September 15, 2017, in regard to an act respecting cannabis and to amend the Controlled Drugs and

Substances Act, I'd like us to say that it should be specifically from 8:30 to 10:30; 11:00 to 1:00; 2:00 to 4:00; and 4:30 to 6:30.

The rest of the paragraph would be the same all the way down until the word "task", where we'd put a period and leave the motion at that—period.

• (1335)

The Chair: Do you think we should have themes for the meetings?

Mr. Colin Carrie: I don't mind having the themes. What I'm saying, Mr. Chair, is that I don't think any themes should be in the original motion, because it would be restrictive, and I would like to have a conversation. We could give it to you guys over the weekend and you could come back with something next week that we can actually talk about. We could pass a motion that's more generalized today so that it gives us some options and gives us some time to think about it.

The Chair: Gary, welcome to the committee. You're up.

Mr. Gary Anandasangaree (Scarborough—Rouge Park, Lib.): No, I'm fine.

The Chair: Mr. Oliver, are you willing to go along with his friendly amendment?

Mr. John Oliver: No. I think the motion as I presented it, with the friendly amendment from Mr. Davies to change the witnesses to proportional to the House sitting percentages....

The Chair: Yes, and with the themes listed.

Mr. John Oliver: Yes, with the themes listed, with the additional ones—I think we added six—and the flexibility of either two- or four-hour sittings, for the clerks to work out the best way for us to do that.

The Chair: Mr. Davies.

Mr. Don Davies: I really think we should vote on the motion now as well. First of all, it's expressed with guidelines, and Colin is right that once it's passed...but we can always revisit it. Let's get this passed and have it written up. Then it can be sent to the committee members. If anybody has a serious objection to that motion as passed, they can certainly move a motion to amend it next week. We're not going to be acting on this right away, but I think it's important. We may not be here next week.

The Chair: Exactly.

Mr. Don Davies: That's why I would suggest that we vote on it now.

The Chair: Dr. Carrie.

Mr. Colin Carrie: I have one more suggestion, maybe as a friendly amendment, John, if this is going to pass today.

After "the following guidelines" in your preamble in the motion, just say "but not limited to", so we would have it in the motion that it's not limited.

The Chair: In reality, any subject can come up anyway.

Now we have a motion. All in favour of the motion as amended?

Mr. Don Davies: Mr. Chair—

Ms. Rachael Harder: Was it accepted to say that?

The Chair: He nodded.

Did you accept...?

Mr. John Oliver: Your thought being that if... How would the clerks respond to “but not limited to”? If we're organizing thematically, how would that happen?

Mr. Colin Carrie: Well, to organize this, with all due respect, we've had a lot of talk on this and I have nothing written in front of me for the motion that we're actually voting on. On Don's suggestion that we just vote on it and if we want to, change it later, I understand that, but we've done a lot of talking back and forth on the motion.

What I'm concerned about, John, is about being too prescriptive, so if we put in a line.... Unless the clerk can read me back exactly everything that was put into it and what we're actually voting on—this is such an important thing and I don't want to rush it—I thought that if we were to put “but not limited to” after your clause, at the front end of it, it just would give us that flexibility that I'm looking for.

I believe everybody's intention is the same, but we know that if there is a discrepancy later on we'll just go back and say, “Well, we did pass this motion.” This gives us a bit more of an open end.

The Chair: I see these as themes, because these conversations go in all kinds of different directions, and we take them wherever we want.

Mr. Webber—

Mr. Colin Carrie: But if we're open—

The Chair: —took it to melting icebergs today, just to give you an idea how flexible the system is.

Mr. Colin Carrie: Yes, but if we are here next week, are we still available to talk about it once the discussion—

The Chair: We can, but I'd like to pass this motion.

Mr. John Oliver: I don't think I'd accept that amendment. It's leaving it too open-ended. I'm not sure how that influences it. I had changed the wording to “to complete the task generally in accordance with the following guidelines” to give that flexibility.

The Chair: “Generally in accordance with”?

Mr. Colin Carrie: You know what? If you need to get this done by—

Mr. John Oliver: We added six more topics to the thing.

Mr. Colin Carrie: At the end of the day, Mr. Chair, I believe this is going to pass, but I would like a recorded vote. It's just this process we're going through that I find a little uncomfortable.

The Chair: All right.

I have Ms. Sidhu.

Ms. Sonia Sidhu: Mr. Chair, John said “following guidelines”, and I think the flexibility will solve your purpose, Dr. Carrie, because it's not in stone: “following guidelines”, with flexibility.

• (1340)

The Chair: Okay.

Mr. Davies, you're on the list. Did you want to say anything?

Mr. Don Davies: I'm okay.

The Chair: All right. We have the motion on the floor. All in favour of the motion?

Mr. Colin Carrie: That's a recorded vote, right?

The Chair: Yes.

(Motion agreed to: yeas 6; nays 3 [See *Minutes of Proceedings*])

The Chair: Now we have a budget that I'd like to pass.

Everybody has a copy of it. Is there any discussion or a motion on the budget?

Mr. Doug Eyolfson: Can we accept the budget?

The Chair: We have a motion to pass the budget.

(Motion agreed to [See *Minutes of Proceedings*])

The Chair: There is no meeting scheduled for Tuesday.

The meeting is adjourned.

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