



HOUSE OF COMMONS  
CHAMBRE DES COMMUNES  
CANADA

45th PARLIAMENT, 1st SESSION

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# Standing Committee on Health

Official Report  
(Hansard)

**NUMBER 015**

Tuesday, December 2, 2025

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Hedy Fry



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## STANDING COMMITTEE ON HEALTH

Tuesday, December 2, 2025

• (1105)

[*Translation*]

**The Chair (Hon. Hedy Fry (Vancouver Centre, Lib.)):** Good morning, everyone.

[*English*]

I call this meeting to order.

Welcome.

[*Translation*]

Welcome to meeting number 15 of the House of Commons Standing Committee on Health.

We recognize that we meet on the unceded territory of the Algonquin Anishinabe peoples.

[*English*]

This meeting is taking place in a hybrid format, pursuant to the Standing Orders.

I want to remind participants of the following points. Please wait until I recognize you by name before speaking. For those participating by video conference, please click on the microphone icon in front of you to activate your mic. Please mute your mic when you're not speaking. Also, at the bottom of your screen, you will see a little globe icon. If you press that, you can get English, French or the floor, whichever you choose.

I remind you that all comments should be addressed through the chair.

When you wish to speak, if you're on Zoom, there's a little hand icon on your computer screen. Please use the "raise hand" function. We don't have any of our committee on Zoom today, so the clerk and I will try to make sure we see your hand and put you in order.

[*Translation*]

**Andréanne Larouche (Shefford, BQ):** Madam Chair, I would like to raise a point of order before the meeting begins.

[*English*]

**The Chair:** I'm sorry. I can't hear her at all.

[*Translation*]

**Andréanne Larouche:** May I read my point of order?

[*English*]

**The Chair:** Excuse me, Madam. I'm putting up my volume. I cannot hear you. I'm sorry.

What are you saying?

[*Translation*]

**Andréanne Larouche:** Madam Chair, I have a point of order.

The study we are working on was undertaken following the adoption, on September 23, 2025, of the motion by my colleague, the member for Montcalm.

While I was substituting for the member for Montcalm at the meeting of October 21, 2025, the committee adopted the following motion to govern the operation of witness testimony for this study: "It was agreed, — That committee meetings be divided into two blocks of one hour each and that a maximum of three witnesses per hour be allowed to testify during meetings."

However, a change was made to the notice of meeting for today's meeting. The five guests will testify in a single two-hour block, from 11 a.m. to 1 p.m. I have a point of order, because the five guests will testify in a single two-hour block, instead of two one-hour blocks each, which is not consistent with the motion adopted on October 21. Since you made this decision without consulting us, I would like you to reset the clock for the second hour of the meeting, which would allow everyone to have another six-minute round of questions.

[*English*]

**The Chair:** I would like to explain that the chair tries to run the meeting so that it is on time and fills the time slot when it's meant to be held. We have been going over time every single meeting we've had so far. I've had complaints from some members that they—knowing that the meeting is supposed to end at one o'clock, or in cases if there are IT problems, maybe a little later—have appointments they cannot keep because the meeting goes on.

It takes time when you have two separate hours to put people on again. We have everybody on now. There is no need to stop at the middle of an hour. I think you're concerned about getting six minutes in the two hours. We could ask the committee if they would be happy to give you another six-minute round without having to do this, because it takes up a lot of time and is very inefficient.

Would the committee agree to allow the Bloc to have another six-minute round?

**Some hon. members:** Agreed.

**The Chair:** Thank you very much, Madam Larouche.

Pursuant to the motion of Tuesday, September 23, 2025, the committee will begin the study of antimicrobial resistance.

I would like to welcome our witnesses.

We have with us Scot Magnish, director of communications and public affairs of ATMIS.

From the Canadian Society of Healthcare-Systems Pharmacy, we have Dr. Rita Dhama. I think she's online.

We have Dr. Kevin Stinson, program manager, Infection Prevention and Control Canada.

From Western University, we have Dr. Sameer Elsayed.

From the Winnipeg Regional Health Authority, we have Dr. Terry Wuerz.

I'd like to explain the process here. Each of you has five minutes to present. I will give you a one-minute shout-out—and I mean shout-out—and a 30-second shout-out so you can know to wrap up. If you don't finish in time, I'm sure you'll get an opportunity during the period for questions and answers to say or expand on what you want to say.

We will begin with Scot Magnish for five minutes, please.

• (1110)

**Scot Magnish (Director of Communications and Public Affairs, ATMIS):** Thank you, Madam Chair, and committee members, for this opportunity.

I'd like to begin by talking about the role infection prevention and control play when it comes to antimicrobial stewardship. I'm sure there are people presenting today who know a lot more about infection prevention and control. I'm approaching this as a manufacturer, and I hope I'll be able to bring some new information to the table.

Our premise is that helping people not get sick is probably one of the best tools we have when it comes to slowing antimicrobial resistance. Our frontline health care workers try to do this in a number of ways. I've worked in hospitals in infection prevention and control. I'm sure you are all aware that there are campaigns across the country about washing your hands. You're also familiar with the role PPE plays in protecting frontline health care workers and the patients they care for simultaneously.

I'm going to focus today on single-use isolation gowns, which play an important part in our system's overall infection prevention and control strategy. Typically, these gowns are made from man-made fabrics like polypropylene. Polypropylene is layered during manufacturing to create spunbonded surfaces with a meltblown centre. Then they're sold in bulk to companies that cut the gowns out of the material and weld the seams together using ultrasonics, and then fold, bag and box them and send them out for shipment. This is what my company does. We have a facility in Chatham, Ontario, of 38,000 square feet, and we use robots to manufacture.

Here's a bit of science. The level of protection an isolation gown offers is determined by how it stands up to fluid penetration in test-

ing, as decided upon by the Association for the Advancement of Medical Instrumentation, or AAMI. The AAMI tells us that we need to test both the gown's material and its seams, and how to conduct these tests, which are typically done by an accredited laboratory.

How a gown performs is determined by several factors, including the quality of the polypropylene, the density of the material and the integrity of the welded seams. A level one gown offers the lowest level of protection, while a level four gown offers the highest. Health care professionals are trained to know which level of gown they need to wear for effective protection. This is where the rubber hits the road. Their decision is based on information the gown manufacturers have provided to the buyers at the institution in question. I'm here to tell you today that that information is frequently untrue.

Here's a series of facts. Number one is that, according to the National Research Council, our country goes through 8.7 million isolation gowns a month.

Number two is that the vast majority of these gowns are made in Southeast Asia, mostly in China. They're imported into America by a handful of companies, which then ship them to Canada and sell them to our health care institutions. These are the same companies that were on deck to provide Canada with emergency PPE when the pandemic hit in 2020, and we all know how that story ended.

Number three is that although these importers have valid Health Canada medical device establishment licences for their warehouses here, the factories making the gowns—many of which are in the Uyghur Autonomous Region of China, in violation of Bill S-211—do not.

Number four is that any company can run multiple tests for compliance with AAMI standards and cherry-pick their results. Nobody needs to know how many times your gowns fail before they finally pass.

Number five is that once you have a lab result, there's no follow-up. If a company changes its material supplier or its place of manufacture, nobody is watching. Nobody is going to know.

Last but not least, number six is that no one is even checking to see whether these labs are authentic. During the pandemic, my company encountered multiple organizations and other companies using falsified lab reports to sell their gowns to hospitals, shared services organizations and even the federal government.

As a result, frontline health care workers were being given sub-standard gowns to wear, some of which were highly flammable, and Canada has over 100 million dollars' worth of isolation gowns in the national emergency strategic stockpile, NESS, right now that were made by companies that provided false lab reports. Fortunately, these gowns were procured by the government and are unlikely to be used. The last of the NESS gowns were delivered in March 2022 with a two-year shelf life, meaning they've long since expired and have not been replaced.

What's the take-away from all of this? If we're going to practise good antimicrobial stewardship, we need to start buying PPE that actually meets AAMI standards. It's a failure that lives at the intersection of our health care procurement policies and procedures, and I think it's having an effect not only on antimicrobial resistance, but on everybody in the country, from hospitals to the federal government.

• (1115)

**The Chair:** I did not give you a 30-second warning. You have 14 seconds left.

I'm sorry.

**Scot Magnish:** The solution is to buy PPE from manufacturing plants with MDE licences and ISO 9001 quality, tracking and traceability. I think making these standards mandatory would advance your work on an antimicrobial strategy or stewardship faster and with broader results than a lot of the other initiatives you could take.

Thank you.

**The Chair:** Thank you very much.

I'll go to the next witness, Dr. Rita Dhami from the Canadian Society of Healthcare-Systems Pharmacy.

Dr. Dhami, you have five minutes.

**Rita Dhami (Chief Pharmacy Officer, Canadian Society of Healthcare-Systems Pharmacy):** Thank you, honourable Chair, and members of the committee.

I am the chief pharmacy officer at CSHP and a clinical professor at the University of Waterloo. I regret that I can't be with you in person today, but I appreciate the opportunity to appear once again to speak about AMR.

When I last presented on AMR, it was for the science and research committee. I focused on evidence; I focused on research. Today, I want to share with you a more personal day-to-day reality and the opportunities I believe we have to act on.

I've been a pharmacist for over 20 years, with nearly half of that time spent as an antimicrobial stewardship infectious disease specialist. I can tell you with confidence that every day, pharmacists across this country confront the consequences of antimicrobial resistance, which include patients who don't respond to first-line treatments; infections requiring more toxic or less effective options; longer hospital stays and preventable complications; and families who are devastated to learn that their loved ones have deteriorated from an infection that became life-threatening.

AMR is not a theoretical risk. It's a present-day reality.

The pan-Canadian action plan on antimicrobial resistance offers a strong foundation. It offers us pillars that we can action. However, it needs some dedicated resources, timelines and sustained federal leadership to meet the urgency of this threat.

First, we have an opportunity to strengthen national surveillance of resistant organisms and antimicrobial use. Canada already has a strong surveillance program through the Canadian nosocomial infection surveillance program, CNISP, which offers both pathogen and antimicrobial-use surveillance in both adult and pediatric in-patient populations.

Work that I've been involved in, the CLEAR registry, further complements the CNISP work by monitoring real-world use of newer antimicrobials. Together, these databases offer a powerful and efficient national surveillance model. CNISP tells us how much antimicrobials are being used, and the CLEAR registry tells us why they are being used. Canada should continue to support scaling these data platforms so that AMR and AMU surveillance can be expanded outside of hospitals into long-term care and community care settings.

Second, we have the opportunity to build sustainable antimicrobial stewardship programs. Accreditation Canada requires that antimicrobial stewardship and infection control be organizational practices for all hospitals. However, we know that the expertise, the data access, and the staffing and infrastructure behind these programs varies widely across the different provinces. We also know that hospital prescribing of antimicrobials is only one part of the picture.

Provinces and territories need support to build sustainable, high-quality stewardship programs across the health care continuum. That includes long-term care, primary care and also the outreach to rural and remote communities. Surveillance data informs stewardship programs and allows clinicians to detect and address the emerging risks sooner.

Third, we have an opportunity to improve access for antimicrobial therapies. Antimicrobial development has not kept pace with the need. We know that since 2010, 18 antibiotics have been introduced globally, but only three of them have had market access in Canada. The Public Health Agency of Canada has done a lot of work on push-and-pull incentives, and that has formed a good foundation for improving access to the antimicrobial pipeline. We now need to move from that sort of exploration phase of the push-and-pull incentives to implementation if we want timely—

• (1120)

**The Chair:** You have one minute.

**Rita Dhami:** —and equitable access to next-generation therapies.

In closing, the next steps are clear: Strengthen surveillance, sustain stewardship, and secure access to effective treatments.

As a pharmacist, I've seen first-hand what can happen when those systems fail and what is possible when they are supported. Canada has the infrastructure and the expertise. What we need now are sustained federal leadership and stable funding to turn those plans into action.

Thank you again for the opportunity.

**The Chair:** Thank you very much.

Now I'll go to Dr. Kevin Stinson, program manager, Infection Prevention and Control Canada.

**Kevin Stinson (Program Manager, Infection Prevention and Control, Waterloo Regional Health Network, Infection Prevention and Control Canada):** Thank you, Madam Chair, and members of the committee, for the opportunity to appear today.

[*Translation*]

I would like to thank the members of the committee for giving me the opportunity to make my presentation today.

[*English*]

I do apologize that I'm unable to attend in person.

In October, I had the opportunity to appear before the science and research committee. I'm quite encouraged to see that this challenge of AMR is being picked up and looked at by so many different aspects of our government. AMR is, after all, a very complex and cross-sectoral threat that truly does require a whole-of-government response.

My background is a microbiologist and an infection control professional. While I work in the acute care sector in Kitchener, Ontario, I'm here today really representing infection prevention and control professionals from across Canada and across the spectrum of health care on behalf of our professional association, IPAC Canada.

AMR has been described as a silent pandemic. What this really means is that a significant aspect of cases and transmission largely goes undetected. We already see significant socio-economic and direct health impacts of AMR, both in Canada and abroad.

Contrary to typical pandemics or epidemics that we think of, especially in recent memory, there's a bit of a unique challenge with AMR as antimicrobial resistant organisms, AROs, have this unique ability to transfer their resistance gene from one bacterium to another, including into the bacteria that occupy our human microbiome, which are the bacteria on our bodies.

This creates a real challenge of persistent colonization, where someone can be persistently colonized, which increases their risk of downstream resistant infections and also of transmission from one person to another. We see today that nearly one in 10 Canadians in acute care hospitals are colonized with at least one ARO. This number increases significantly when we look at low- and middle-income countries abroad.

AMR is, after all, a global threat that really does not know any borders. Effectively controlling and responding to this threat re-

quires coordinated efforts along the lines of surveillance, infection prevention and control, IPAC, as well as antimicrobial stewardship.

In health care settings, infection control professionals, ICPs, form a backbone of the core personnel required and responsible for implementing these strategies. However, we see inconsistencies across Canada in how IPAC programs are implemented as well as in access to trained and certified ICPs in all health care settings.

From a surveillance lens, Canada's surveillance program broadly acts to give large-scale, generalized AMR trends, but it lacks the depth and the breadth to be able to actually map transmission, and it lacks the granularity to be able to take that data and apply it to influence practice at a local level.

Infection control professionals rely on good, solid evidence and good, solid surveillance data to optimize our AMR control and surveillance strategies within our facilities to both meet the needs of our communities and balance clinical operations and financial stewardship. Without this data, we're left trying to take generalized data and are unable to apply it directly. These disparities are especially prominent in rural settings or sectors outside of acute care.

To address these problems, we need to look at building our infection control capacities in the health care workforce through training and capacity development initiatives, such as what we see with the IPAC hub program that is currently operating across the province of Ontario.

When we look at longer-term strategies, Canada really needs to look at improving its overall AMR surveillance program.

**The Chair:** You have one minute.

**Kevin Stinson:** What we need is an integrated multi-sector approach with a specific focus on understanding transmission dynamics and using that to find control measures both in and out of the health care setting.

We also must continue to look at how Canada can support broad public health initiatives, such as backing vaccination campaigns, which are aimed at preventing infectious diseases and which indirectly do support antimicrobial stewardship efforts.

With that, I would again like to thank you all for the opportunity to present today. I will be submitting a written brief as a follow-up to this session, outlining these points in greater detail. I certainly welcome your questions.

Thank you very much.

• (1125)

**The Chair:** Thank you, Dr. Stinson.

I now go to Dr. Elsayed from Western University.

You have five minutes.

**Sameer Elsayed (Infectious Diseases Physician, Western University):** Good morning, Madam Chair, and honourable members. Thank you very much for the invitation. It's an honour and a privilege to appear before this committee to answer your questions and to speak about antimicrobial resistance and its impact on the health of Canadians.

My name is Dr. Sameer Elsayed. I'm an infectious diseases physician and medical microbiologist at London Health Sciences Centre, and a full professor at Western University. My educational credentials also include advanced degrees in public health and health care quality. I've been practising as a clinician, educator and researcher for over 25 years and have held several leadership positions throughout my professional career.

In 2009, I was appointed chair of the antimicrobial medication committee at London Health Sciences Centre and continue to serve in this capacity. Since 2013, I have served as the physician lead for the antimicrobial stewardship program at London Health Sciences Centre, and as the program's representative on the hospital's quality and patient safety committee. From 2017 to 2020, I served as the elected chair in infectious diseases at the Ontario Medical Association. In 2018, I was appointed director of the adult infectious diseases residency training program at Western University and continue to provide educational oversight of this program.

The topic under discussion today is near and dear to me, and one which all Canadians should take to heart, including policy-makers, researchers, health care administrators, regulated health professionals and members of the general public.

According to the World Health Organization, antimicrobial resistance, commonly referred to as AMR, is currently one of the top 10 global public health threats to humanity. In 2021, AMR was directly responsible for over 1.1 million deaths and contributed indirectly to an additional 4.7 million deaths.

Scientific modelling studies predict that by the year 2050, these numbers will double, and annual excess health care costs due to AMR will exceed \$2 trillion U.S. without appropriate action by governments, the health care community at large and other global stakeholders.

Antimicrobial resistance affects all geographical regions, income levels and age groups. It compromises the ability of the health care community to provide safe and effective treatments to individuals suffering from infectious diseases. AMR is often referred to as a silent pandemic, because it typically spreads unnoticed. AMR is linked to several human behaviours. Misuse of antimicrobials involves selecting the wrong antimicrobial agent, dosage or duration of treatment due to diagnostic uncertainty, lack of knowledge or patient demands.

Overuse relates to antimicrobial use that is considered unnecessary, for instance, treating a viral infection with these medications. In some countries, there is unregulated access and minimal oversight of antimicrobial use in humans as well as in animal husbandry.

In Canada and many other high-income countries, approximately 50% of antimicrobial prescriptions in community settings are considered inappropriate—in other words, misuse or overuse. These numbers are slightly lower in hospital settings, at around 30%.

In 2013, antimicrobial stewardship, AMS, practices became an accreditation requirement for all Canadian acute health care facilities. In contrast, AMS became a mandatory practice for acute care hospitals and long-term care facilities in the United States in 2017. Currently, long-term care homes in Canada are exempt from this requirement, even though they bear a large burden of inappropriate antimicrobial use.

There is a natural cycle of antimicrobial use and its consequences that involves humans, animals and the environment. Agricultural use of medically important antimicrobials in Canada and the U.S. is more than twice that in humans. On a per capita basis, use of antimicrobials in Canadian livestock exceeds that of the U.S. and most European countries. Antimicrobial-resistant organisms can spread from animals to humans through food, contamination of waste water—

**The Chair:** You have one minute.

**Sameer Elsayed:** —and crops, and even via transmission of animal wastes to birds, ticks, flies and rodents that may come into contact with humans. Human waste from hospital sewage systems contains AMR organisms due to heavy antimicrobial use, which eventually enters our water supply, the natural environment and food-producing animals, repeating this never-ending cycle. Approximately 75% of all infections caused by AMR pathogens are—

• (1130)

**The Chair:** You have 30 seconds.

**Sameer Elsayed:** —acquired in hospital settings, while the remaining 25% occur through environmental exposure, international travel and direct contact with animals.

Fortunately, several concrete steps have been taken by the Government of Canada and provincial and territorial governments to mitigate the burden of AMR by supporting initiatives that promote the judicious use of antimicrobials. In this regard, the pan-Canadian action plan on antimicrobial resistance was launched in 2023, and is built on five pillars: research and innovation, surveillance, leadership, infection prevention and control, and antimicrobial stewardship.

However, there are still gaps that need to be addressed, including expedited regulatory approval for new antimicrobials, increased restrictions—

**The Chair:** I'll ask you to wrap up, please. You can elaborate on it during the question and answer period.

I'm sorry.

**Sameer Elsayed:** Thank you.

**The Chair:** I go now to Winnipeg Regional Health Authority and Dr. Terry Wuerz, infectious diseases physician.

Dr. Wuerz, you have five minutes.

**Terry Wuerz (Infectious Diseases Physician, Winnipeg Regional Health Authority):** Madam Chair, vice-chairs, honourable members of the committee, thank you for the invitation to speak today.

My name is Dr. Terry Wuerz, and I'm a practising infectious diseases physician from Winnipeg.

Antibiotics are foundational to modern medicine. They're not just treatments for infections; they're enablers of routine and life-saving care. Every day in Canada antibiotics make it possible to safely perform surgical procedures such as joint replacements and C-sections, chemotherapy and immunosuppressive therapy for cancer and autoimmune diseases, organ transplantation, intensive care interventions and safe care during premature labour or neonatal complications. Without effective antibiotics, these cornerstones of modern health care become unsafe or impossible.

However, the effectiveness of antibiotics is not guaranteed. We are already seeing them diminish.

One way to think about antibiotics is as a finite resource. I often describe them as a trust fund. Every time we prescribe one, we withdraw a little from that fund. When antibiotics are used appropriately, they save lives. When they are overused, misused, or used in situations where they provide no benefit, antibiotic resistance accelerates. If we don't reinvest in this resource through careful stewardship and access to new drugs, we risk stealing from the future to treat patients today. The consequence of that erosion is visible on the front lines.

In Manitoba and across Canada, we're seeing infections that no longer respond to first-line antibiotics, more frequent use of toxic or costly last-line drugs and sharply rising rates of resistant infections in both hospitals and in the community. Increasingly, we're encountering cases where no antibiotics work at all. These infections are caused by totally drug-resistant organisms—bacteria resistant to every available antibiotic in Canada. When that happens, we may be left with only one option, source control, meaning the physical removal of infected tissue. In the most severe cases, that could mean amputation of an infected limb. These are devastating outcomes for our patients and their families, and they represent the direction our health care system is headed if we don't act now.

We know what interventions reduce resistance and protect patients. The most effective is antimicrobial stewardship: the coordinated effort to ensure the right antibiotic is used only when necessary at the correct dose and duration. Stewardship programs save lives, reduce adverse drug events, shorten hospital stays and decrease the development of resistance. There are also cost savings for the health care system. Yet, despite the evidence, stewardship programs across Canada are chronically underfunded.

In my own province of Manitoba, including in our largest tertiary care hospitals, there is no dedicated stable funding for antimicrobial stewardship programs. This means that programs operate intermit-

tently, rely on voluntary effort, or disappear when the temporary funding ends. We cannot protect antibiotics without protecting the programs that ensure they're used safely and appropriately.

Another challenge is access to new antimicrobials. Canada lags behind peer nations in bringing new antibiotics to market. Only a small fraction of newly developed antibiotics ever reach Canadian clinicians, and when they do, the path to reimbursement and formulary access is often delayed by years. This leaves clinicians caring for patients with highly resistant infections with very few options. The federal government already has a road map, the pan-Canadian action plan on antimicrobial resistance. It was released in 2023 and outlines the right priorities: stewardship, research, innovation and coordinated leadership across federal, provincial and territorial partners. What it does not yet include is implementation funding, timelines or mechanisms to ensure stewardship programs exist wherever antibiotics are prescribed.

To make meaningful progress, I would highlight three actionable federal priorities.

One, fund and standardize antimicrobial stewardship programs in all health care settings: acute care, long-term care and community practice. Stewardship is one of the most cost-effective interventions we have.

• (1135)

Two, support rapid access to new and effective antimicrobials through streamlined regulatory pathways and incentives.

Three, enable national coordination of antimicrobial resistance policy and implementation.

Antibiotics made modern medicine possible. If we protect them, Canadians will continue to benefit for generations. If we fail to protect them, we will see more preventable deaths, more avoidable amputations, more treatment failures and rising health care costs.

[Translation]

Thank you. I look forward to your questions.

[English]

**The Chair:** Thank you very much, Dr. Wuerz.

I'll now go to the question and answer segment. In these segments, the first one is a six-minute segment, which means that the six minutes is for the question and the answer. Please be as concise as you can, everybody, so that we can get in as many answers as we can.

I'll begin with the Conservatives and Dan Mazier for six minutes, please.

**Dan Mazier (Riding Mountain, CPC):** Thank you, Chair.

Thank you to the witnesses for coming here today.

Mr. Magnish, you mentioned that Canada's national strategic stockpile contains expired medical gowns. What evidence supports this?

**Scot Magnish:** We can go back to the pandemic in 2022. In 2022, I was part of a team that delivered the last isolation gowns to the national emergency strategic stockpile. That was in March. They had a two-year shelf life, so those gowns expired in 2024.

I can tell you that as a company interested in this market, we watch the CanadaBuys site very closely. That's where the Government of Canada tenders all of its procurement. We know that in September 2022 there was an RFI on CanadaBuys looking for ways to dispose of the stockpile, but there was never an RFP, request for proposal, ever issued.

We also know from CanadaBuys that the government not only has yet to tender that RFP or RFSO, but has renewed contracts with the same companies that let us down during the pandemic. They've extended those contracts, the last one as recently as in August of this year.

While there may be product in the national emergency strategic stockpile, there are definitely no gowns. What material we do have, we also know is being sold through GCSurplus.ca, which is where the Government of Canada disposes of surplus product. They created a new category on that website this year for PPE, and they're selling masks, gloves and other products there for pennies on the dollar.

**Dan Mazier:** Do you believe it's appropriate or even safe for Canada to rely on expired protective gowns in the event of a health emergency?

**Scot Magnish:** No, it's absolutely not safe. Those gowns have a shelf life for a reason. Ostensibly, it's because they will perform at their advertised safety levels for that period of time, after which the amount of protection they offer drops.

We also know that a significant number of gowns were sold to the Canadian government with false lab reports, so we don't even really know how those gowns could perform in the first place. It's a big mystery. We do know that many of them are flammable.

**Dan Mazier:** Mr. Magnish, what proportion of the protective equipment in Canada's national strategic stockpile currently comes from China?

**Scot Magnish:** Right now, if Canada were to procure again through one of those companies that was on the 2020 requests for RFSOs, requests for standing offers, all of those companies import from China. If the Government of Canada deemed it necessary to

procure gowns, which it ought to because they have none, right now they would all come from China.

• (1140)

**Dan Mazier:** One hundred per cent?

**Scot Magnish:** One hundred per cent.

**Dan Mazier:** Wow. Does this reliance on PPE from China create a health and safety risk?

**Scot Magnish:** I believe it does when you take a look at the quality of the product that is being imported. It's, as I said, often inferior. It's not made in an MDEL facility. We know that much of it is highly flammable. We know the labs are suspect.

It really comes down to a price point and also what the system is used to. The system is used to procuring through these large medical device suppliers, and it's incredibly price sensitive. As everybody around the table knows, you don't want to lay off nurses so you can buy better gowns if everybody is happy with the gowns. The thing is, they ought not to be.

**Dan Mazier:** Mr. Magnish, the media reported that Health Canada lost more than \$20 million in health supplies from Canada's national emergency stockpile. Unfortunately, the government won't provide the specific details on this, citing national security. I think Canadians deserve to know why the government lost \$20 million. Is this a national security issue or is this a bigger issue that the government is trying to hide?

**Scot Magnish:** I can't speak to the issue of the vaccines, because we don't make vaccines; however, we do make PPE. I don't know how it could be national security if it's advertised on CanadaBuys. If the offers to procure are made in a public way, in a public forum, then, ostensibly, it's not national security. It's in the public's interest. I think that's why there is so much transparency there and why that website was created.

**Dan Mazier:** Mr. Magnish, based on your experience, what is the biggest concern with how the federal government is managing Canada's national strategic stockpile today?

**Scot Magnish:** I believe it isn't. I believe that they have essentially allowed it to expire.

What they have, they're selling off at pennies on the dollar. They've renewed contracts with Metro Logistics, their warehousing company, to continue to warehouse expired product at a cost of \$34 million a year. As a taxpayer, I take umbrage with that. This is the second year that this has happened, so it's \$68 million to store expired PPE.

**Dan Mazier:** Thank you, Mr. Magnish.

Thank you, Chair.

**The Chair:** Thank you very much.

I'll now go to the Liberals and to Helena Jaczek.

Ms. Jaczek, you have six minutes.

**Hon. Helena Jaczek (Markham—Stouffville, Lib.):** Thank you, Madam Chair.

I'd like to start with Dr. Elsayed.

You were telling us your opinion of the 2023 pan-Canadian action plan on antimicrobial resistance. You, I think, endorsed five pillars, but you were going to explain to us what you felt were some gaps. Perhaps you could take this time to elaborate a little bit on what you see as gaps in the plan.

**Sameer Elsayed:** Madam Chair, I would answer that this way. The gaps that exist right now are the expedited regulatory approval for new antimicrobials. This is urgently needed at the federal level. The delay between the availability of newer antimicrobial agents in the U.S. and Europe and their introduction to the Canadian market often exceeds seven years, if they become available at all. Many clinicians in my field rely on the Health Canada special access program to secure access to some of these newer antibiotics; however, the process isn't feasible for managing life-threatening infections. For some medications, it might be next-day delivery, but for others it might be three weeks.

There are also shipping costs involved. For some of the drugs, we have to sign a contract with the manufacturer, and that contract might involve shipping costs that are in the thousands. Again, a delay of three weeks would be unacceptable in this type of setting for a life-threatening infection.

One of the other panellists commented that since 2010 three of, I think, 15 antimicrobials have been approved by Health Canada. In the last 10 years, only one of six that are designed specifically to target the critical priority pathogens, according to the World Health Organization, have been approved by Health Canada. There was one that was just approved in May or June of this year. That's just one, but there are five or six other ones we need access to when we're going through the special access program. I don't think it's a problem with the special access process; it's just the actual delay.

The other thing that needs to be done is there needs to be an online portal for the SAP, the special access program. Right now, we deal with phone calls, faxes and paper. It's very manually labour intensive. I think that process needs to be improved so we can speed up the process and make it more transparent.

There are three other things.

The other thing I wanted to highlight is the increased use of antimicrobials in domestic agricultural practices. Antibiotics are used as growth-promoting products. The use of antibiotics in animals obviously carries itself through to the food chain, and then to humans, and then to the environment. There should be some limits on the use of antibiotics in animal husbandry.

As other panellists have mentioned, antimicrobial stewardship programs should be mandatory. Dr. Dhama commented that even though it's mandatory for acute care facilities, there's lots of variability. Some places I know don't really have a good antimicrobial stewardship program, even though they're supposed to have one.

I have in my written notes but I ran out of time to say that the antimicrobial stewardship requirements in the U.S. are different from those in Canada. In the U.S., all long-term care facilities require the implementation of an antimicrobial stewardship program. In Canada, we don't have that. This is very critical because elderly

people in nursing homes bear a large burden of antimicrobial resistance, and so practices that can help mitigate unnecessary use of antibiotics are essential in that setting.

There needs to be increased funding for hospital infection control in antimicrobial stewardship programs. That's kind of related to what I already said.

Those are the four main points: expedited regulatory approval of newer antimicrobials; increased restrictions on domestic agricultural practices; mandatory antimicrobial stewardship programs going beyond the acute care facility—I also agree that they should be implemented in the community, as I believe Dr. Stinson or one of the other panellists mentioned—and then increased funding for existing hospital infection control programs and antimicrobial stewardship programs. Seventy-five per cent of the burden of antimicrobial resistant infections occurs in hospitals; the other 25% occurs in the community. Therefore, a focus on hospitals should be a priority by the government.

I appreciate the questions. I hope the answers will stimulate further discussion.

• (1145)

**Hon. Helena Jaczek:** Thank you so much. That was very helpful.

Dr. Dhama, you made a comment related to the fact there were only three of these newer antimicrobials available in Canada, even though worldwide there were some 18, or thereabouts, available. Why is this?

What we've heard from some at the science and research committee is that some pharmaceutical companies are loath to even apply for use in Canada because the market is small and perhaps there isn't the financial incentive to invest in the Canadian need in health care.

Are you aware of what has happened in terms of access to these new antimicrobials in Canada?

**Rita Dhama:** What we do here from our pharmaceutical industry colleagues is.... Unlike other drugs, antimicrobials are often prescribed for shorter or time-limited courses of treatment. We also know that while stewardship programs improve and optimize the use of antimicrobials, they can also have that detrimental effect of limiting the growth potential of antimicrobials.

From our—

**The Chair:** Can you wrap up, please, Dr. Dhama? We're well over time in this round. You can elaborate in another round when someone else asks you a question.

**Rita Dhama:** Sure. No problem.

**The Chair:** Thank you very much. I'm sorry about that.

I'll now go to Ms. Larouche from the Bloc for six minutes, please.

[*Translation*]

**Andréanne Larouche:** Thank you very much, Madam Chair.

Since this is the Standing Committee on Health and I'm wearing a red ribbon, I think it's appropriate to quickly remind you that yesterday, December 1, was World AIDS Day, an important day. We still have a long way to go in 2025.

Dr. Magnish, you spoke in your opening remarks about procurement in China, and my Conservative colleague also asked questions about that. You reminded us of the importance of avoiding sourcing from places where forced labour is used. You cited, among other things, the case of the Uyghurs in China. You also mentioned the impact, as we understand it, on product quality.

On October 21, our party introduced a bill to put an end to what we call the funding of modern slavery, particularly so that Canada can take note of the fact that not all countries produce goods under the same conditions, as in the example of China and the Uyghurs.

So a bill like this is important to reduce the arrival of products, particularly in the area of supplying garments or personal protective equipment. What impact would a bill like this have?

• (1150)

[*English*]

**Scot Magnish:** I should point out that you gave me a raise. I'm not actually a doctor, but thank you.

In terms of protecting the importance of this issue, I believe that we actually have legislation right now in Canada, Bill S-211. I'm not sure if there's something new in the works or if the government or your party is introducing something, but it's absolutely important.

If you look at the issue here, man-made textiles coming out of the Uyghur Autonomous Region are one of their leading products. It is one of the top things they make. We're talking about a population who most governments around the world have agreed are living in forced labour camps to make dangerous products.

This is all in violation of Bill S-211 already. The problem with Bill S-211 is that nobody's enforcing it. Companies have to attest to the steps they've taken to purge forced labour from their supply chains every year. They file that with the Minister of Public Safety, I believe. Companies are doing this, but it's essentially a checklist where they just check a box and say they have no forced labour.

There are small steps they claim to take around the training of their employees, but I can tell you that if you open up a catalogue from one of Canada's leading health care suppliers, pick a product—which is literally what I did—and then run it through an open source database run by human rights groups, you will find forced labour. You'll find products being made with forced labour.

The government has renewed contracts with some of these companies. Certainly, our health care institutions have too. In every single hospital in Canada, I guarantee you will find products that have been made with forced labour.

Anything we can do to address this as Canadians is important. It takes a step away from antimicrobial stewardship, but quality prod-

ucts can only help us in that regard as well. It starts, though, with actual enforcement. Somebody needs to investigate these companies and lay fines just as the act gives somebody the power to do.

[*Translation*]

**Andréanne Larouche:** Thank you very much, Mr. Magnish. I'm sorry about the promotion, it's just that we're surrounded by doctors today.

By the way, the criticism of the legislation that came out of Bill S-211 is precisely that it doesn't go far enough. That is why the Bloc Québécois introduced a bill to go a little further and give the act more teeth.

Dr. Elsayed, you concluded your remarks quickly, because your time was up. I'll give you the opportunity now to share elements of your conclusion that you didn't have time to give.

[*English*]

**Sameer Elsayed:** Madam Chair, I'd be happy to answer that question.

The other thing I want to mention is that the lack of access to some of these newer antimicrobials is not just about mortality. Mortality is a big thing and something we think about. We have seen an increased number of deaths in our hospitals, especially during the COVID-19 pandemic. We had multi-drug resistant organisms that we needed to go through the special access program. During that time, it was very challenging, as we didn't have the drugs on hand.

• (1155)

It's not just about mortality. There's also increased pressure in the hospital system in terms of the census of hospitals. For instance, if we don't have access to one of these first-line antibiotics through the special access program, we have to use a second-line agent, which not only doesn't work as well usually, but also has more toxicity. The patients end up staying in hospital for a longer period of time.

There's also some misalignment with the clinical practice guidelines and the drugs that we have access to. That needs to be looked at from the federal side, but especially on the provincial side, where we want to send patients home on an antibiotic and there's no coverage there.

I'm happy to address other questions but, because of the time, I'll conclude there.

**The Chair:** Thank you very much.

I'll now go to the second round.

I will begin with Mr. Epp from the Conservatives.

You have five minutes, please, Mr. Epp.

**Dave Epp (Chatham-Kent—Leamington, CPC):** Thank you, Madam Chair.

Thank you to all the witnesses for appearing today.

I'm going to focus on Mr. Magnish for my questions.

In your testimony, you referenced fact number two, saying, "We all know how that story ended." You were referencing the fact that we were dependent upon China for our PPE.

Can you elaborate a bit more on exactly what you mean by how that story ended?

**Scot Magnish:** That story started in 2020. The federal government issued an RFSO, a request for standing offer, to companies to supply the national emergency strategic stockpile. There was nothing wrong with that RFSO. They awarded it to several different companies. They were the same companies that supply the hospitals and the same companies that you're probably all familiar with.

The problem is that all these companies source their material or their products from overseas, mostly China but Southeast Asia as well. When the pandemic hit, they could not continue the supply. I'm sure that everybody in this room can remember the Prime Minister at the time asking companies in Canada like ours to pivot their focus and manufacture personal protective equipment. Nurses were wearing scarves wrapped around their faces.

This is how that story ended. The pandemic finally subsided, and Canadian companies like ours had stepped up and were supplying the national emergency stockpile. Life got back to normal, and everybody started buying products from China again. Hundreds of millions of dollars were spent standing up Canadian industry on this front. It's an industry that's probably worth about \$1 billion a year, and we gave it all back to China.

Let me just add one last thing. We're still doing it. As late as August of this year, we renewed one of the contracts with one of those same companies, and we extended it for another nine months. This is strategically disastrous, because we know exactly what happens when we put all our eggs in one basket.

**Dave Epp:** Mr. Magnish, I have toured your plant. I have seen the 20 robots, and they're sitting idle right now. Is this an issue of cost? Is that why the industry has gone back? This is unfathomable.

We have an entire country trying to reshore right now, yet we are sourcing from China and, as Madam Larouche alluded to, potentially with forced labour as well.

What's going on here?

**Scot Magnish:** It's about the cost, definitely. Our hospitals all struggle with budgets, and they look for the best price they can get. Asia is able not only to provide lower costs because of the lower human labour costs, but they're also able to manipulate the market, because they are state run. If they want it to be cheaper, they can just make it cheaper.

As a result, it makes it very difficult for Canadian companies to compete. Our competitive advantage, as I said, is that we make our gowns with robots equipped with lasers and ultrasonics.

**Dave Epp:** I hate to put you off, but I do want to get more in.

That's fine if we're comparing apples to apples. My understanding is that we're not comparing apples to apples when it comes to quality.

You mentioned that some of these gowns are flammable. Can you prove that?

**Scot Magnish:** Yes. In anticipation, I brought a video that I can share with the committee at your leisure. It's on a memory stick that I can leave with somebody.

We did a side-by-side test of hospital gowns pulled from a local hospital in southwestern Ontario, and we set them on fire to see what would happen. There is no shortage of evidence. You could buy one today—they're all publicly available—just to see how they perform. We've tested our Chinese competitors' gowns, and they're definitely inferior. We can beat them or at least meet them on price because of the competitive advantages that we have.

The second part of this is that it comes down to preferences, where doctors might just like a particular brand. They've already gone through the process of vetting it. They're comfortable with it, so they just keep buying it.

• (1200)

**Dave Epp:** Right now, our government is going for a cheaper route as opposed to a safe route. They're going to a foreign supplier as opposed to a domestic supplier when we have the capacity right here.

**Scot Magnish:** That would be a correct assessment, yes.

**Dave Epp:** Would it also be an accurate statement that right now, our NESS, our national emergency strategic stockpile, is in worse shape than it was going into the pandemic?

You talked about expired goods, where polypropylene degrades over time. The quality of those very same gowns is suspect, based on your testimony.

**Scot Magnish:** Yes, it is. We are in worse shape today than we were at the beginning of the pandemic, in terms of preparedness.

**Dave Epp:** Thank you, Mr. Magnish.

**The Chair:** Thank you very much, Mr. Epp.

I'll now go to the Liberals with Ms. Sidhu for five minutes please.

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

Thank you, witnesses, for coming here and for your very informative testimony.

My question is for Dr. Sameer Elsayed.

Dr. Sameer, you talked about the guidelines on antimicrobial medications. How can strengthened federal stewardship initiatives, such as national prescribing guidelines, support physicians in reducing inappropriate antimicrobial usage? One aspect is around how to reduce this, and the second aspect is around the guidelines in hospitals.

I want to share a story. Just last month in Brampton, a kid lost his mother because of sepsis. My question for you is, how could federal-provincial collaboration improve equitable access to rapid testing and to the new antimicrobials you said we need to access?

**Sameer Elsayed:** Madam Chair, we do have national guidelines for treating various infectious diseases, but we also rely on guidelines published in other countries, especially in the United States and also in the U.K. They have different health care systems and different kinds of funding programs. Some of the medications that are newly available in these countries are very expensive, and that's obviously one of the biggest barriers.

We also publish and develop our own local clinical practice guidelines for how to treat different infectious diseases. We actually have a web page in our hospital that talks about how to treat bloodstream infections, urinary tract infections, etc.

For antimicrobial stewardship programs, which I'm actively involved in at my hospital as the physician lead, we are an advisory program. That means we can educate and develop clinical practice guidelines, but we cannot force physicians—or twist their arms, if you want to put it that way—in terms of how they can treat an infectious disease.

We do have influence on the hospital formulary regarding what antibiotics we have available in our hospital and who's allowed to prescribe them. For these newer antibiotics for the AMR pathogens, there would need to be a gatekeeping function in the hospital so that they're prescribed appropriately.

I'm sorry to hear the story about the child's mother dying. I may have read the story already because I do look at and read these cases in the news so that it doesn't happen again, and I reflect on it. I don't know how that occurred, whether there was a delay in initiation of therapy or whether it had to do with a drug-resistant organism.

There is a disconnect between the federal and provincial and territorial health programs in terms of antibiotics. For instance, we do have Health Canada approved antibiotics that we use in hospitals, but they're not covered by the provincial formulary.

For instance, in Ontario, we have to go through the exceptional access program. I've had requests denied very frequently, even for something that's clearly recommended by clinical practice guidelines. I do believe there are some outdated guidelines as well that the Ministry of Health in Ontario uses. I know this is not a provincial forum here, but I can tell you there is a bit of a disconnect.

Health Canada generally will not approve a medication for outpatient use if it's not approved by Health Canada, so there's that issue.

However, clinical practice guidelines exist for many different infections. There are differences of opinion. For instance, in treating

eye infections, there's a difference of opinion between the Infectious Diseases Society of America and the American Academy of Ophthalmology in terms of how to treat them, so that may get in the way for certain things.

In general, though, we do have good clinical practice guidelines. We know how to treat these infections with first-line therapies. Really, the problem is having Health Canada approval. That process is delayed much more than the processes are in the European Union and the U.S., for instance. I think that's one thing.

I hope I answered your question well, and I'm happy to answer any other questions later on.

Thank you very much for the opportunity.

• (1205)

**The Chair:** Thank you.

Thank you, Ms. Sidhu.

**Sonia Sidhu:** Thank you.

**The Chair:** We'll go now to Madam Larouche for six minutes.

[*Translation*]

**Andréanne Larouche:** Thank you, Madam Chair.

Dr. Elsayed, in your opening remarks, you raised the issue of agriculture. You said that the antibiotics used in agriculture in the United States and Europe are not the same. Why is the reciprocity of standards for products imported here important?

[*English*]

**Sameer Elsayed:** Madam Chair, that is a very good question. I wasn't expecting to get that question today, but I'm happy to answer it.

Certainly, let's look at it from an individual perspective. If you are residing in Canada and you travel to a country where there is a high burden of antimicrobial resistance, and let's say you're there for a while or you're hospitalized, you will likely be colonized, meaning the normal bacterial composition of your skin or intestines will likely have some of those antibiotic-resistant bacteria. You're going to take it back with you, and you're not going to be able to get rid of it probably for about half a year. If you get medical care in another country, there's a high risk of getting an infection with an antimicrobial-resistant organism.

I was the first physician in southwestern Ontario to see an antibiotic-resistant infection from a certain strain that came from overseas in east Asia. There were no treatments available at the time. Fortunately, it was a urine infection and we decided just to watch it. It wasn't in the bloodstream.

The same thing would go for agricultural products that are imported into Canada. I don't think we really know what's going on in that regard. We do have data from the U.S. and Europe, but also from China, where there is a heavy use of antimicrobials in their agricultural practices. I don't know about specific countries. In Canada, the biggest use of antibiotics is in beef livestock. That accounts for a higher proportion than in other animals.

I would say that importing especially meat products is where the antibiotic-resistant issue would be of most concern. Fortunately, we have great dairy and beef industries in Canada, and hopefully most of what we use is from domestic sources. I know that we get sources from the United States.

I don't think it's an issue so much with plant-based products. There are not a lot of antibiotics used in crops. Although there are some, they're a minor component. It's more for meats.

I'm not an expert in that area. I gave a talk recently, during World Antimicrobial Awareness Week, which was held during the third week of November. It's celebrated across the world. I had a few PowerPoint slides showing how antibiotics are being used in our domestic cattle and in the food-producing animal industry. I kind of researched what was going on in other countries, but I don't have a lot of information because that's not my area of interest.

That's a very good question, and I believe that is a concern. If we're importing meats, then we need to look at that. It's also a health security issue, if you want to put it that way.

That's all I have to say. I appreciate the question and I'm happy to answer any more later on.

• (1210)

[Translation]

**Andréanne Larouche:** This is one of the requests made by Canadian processors, who have an office in Granby, in my riding of Shefford. Animal products imported here are not subject to the same rules abroad. We've observed that there are consequences to the ways antibiotics are used.

Dr. Dhama, pharmacists play an important role, particularly in hospitals. A number of speakers raised the issue of inappropriate prescriptions. What role could you play specifically with regard to this problem?

[English]

**Rita Dhama:** As a pharmacist, we are the experts in drug therapy. Many pharmacists who specifically practise in the infectious diseases antimicrobial stewardship space have done extra specialization, certification and training to really get a good understanding of how antimicrobials are prescribed and those sort of bigger picture impacts.

As a pharmacist, if we observe or come across antimicrobials that are not guideline concordant, the first step is to have a conversation with the prescriber, whether that's a physician, nurse practitioner or a colleague pharmacist. A lot of pharmacists across the country now can prescribe antimicrobials for minor ailments. Really, the first step is to get the lay of the land of what's happening with the patient, assess the situation and understand if there's an opportunity to optimize the therapies that are prescribed.

There is actually a study out of Nova Scotia that compares antimicrobial prescribing amongst different health care professionals. Interestingly, pharmacists tend to be the health care professionals who are the most likely to prescribe within guidelines and maintain guideline concordance.

**The Chair:** I'm going to the next questioner. It's Mr. Strauss for the Conservatives for five minutes, please.

**Matt Strauss (Kitchener South—Hespeler, CPC):** Thank you, everyone, for being here.

It's lovely to see southwestern Ontario so well represented and Kitchener-Waterloo in particular. It's also lovely to see Dr. Sameer Elsayed, who was my professor at Western some 15 years ago.

Dr. Elsayed, I won't ask you to answer this question, but when you were talking about the special access program—you outlined your CV and I know you to be a tremendous clinician and expert in the field—the idea of the special access program not giving you access to a medication you think is necessary and life-saving in a reasonable amount of time, I confess to just feeling enraged, because if Dr. Elsayed thinks it's necessary, then it's necessary.

Maybe I'll put that question to Dr. Wuerz.

What reflections do you have on that? I take it you're an infectious disease specialist—very much like Dr. Elsayed—in Winnipeg. This process seems crazy to me. If you think it's necessary, surely it should be offered.

**Terry Wuerz:** Madam Chair, absolutely, I believe that the process to obtain drugs through the special access program can often be a problematic one. I don't mean to fault the people working in that program, but the fact is that waiting up to three weeks for an antibiotic is absolutely unacceptable when we're talking about conditions like sepsis. Even a few days or a day is harmful or potentially harmful.

I've worked for almost 15 years as an infectious disease physician. I work in tuberculosis. In tuberculosis, we're seeing increasing risks of drug-resistant infections. The only option in the case of something called multi-drug resistant tuberculosis is to use antibiotics that are not available in Canada. Two out of the three antibiotics that are the first line for multi-drug resistant tuberculosis are not available in Canada, so it needs to be an application through the special access program.

The program is infuriating, to use the honourable member's words. We have a case with a very clear-cut indication, with multiple international bodies agreeing what should be the accepted treatment, yet it takes days or longer to obtain the approval and sometimes the response you will get is quite variable. Maybe you'll get a response back asking if you can justify that a little further or saying that you didn't include what you're going to monitor for or what have you. Other times, it will go through. The process is opaque, takes too long and needs to be streamlined.

• (1215)

**Matt Strauss:** Thank you for the answer.

You're very polite to say you didn't mean to fault anybody in the program, but I think I do mean to fault them. It's totally unacceptable. I won't move a motion now, but maybe I'll put it in the committee's ear that we need to call officials from that program to justify this. I am an intensivist. I deal with life-threatening emergencies, and it would just drive me bananas if Dr. Elsayed were there saying that my patient needed a medicine to survive and a bureaucrat was not providing it.

Dr. Elsayed, you spoke a little bit about how the AMR program or antimicrobial stewardship program doesn't twist arms, but that it is educational. When I think about the program as being educational.... Actually, I had a bout of hemorrhagic enterocolitis this past summer. The family physician I saw was using AI to recommend drugs to me. If AI were integrated into hospital EMRs to say, for example, that a patient with pneumonia has been on antibiotics for 10 days longer than they need to be, it seems that a lot of that could be automated.

What do you think of that? Is there interest in moving towards that?

**Sameer Elsayed:** Madam Chair, I'm happy to answer that question.

It's nice to see the honourable member again. I worked with him before—supervised him before.

The antimicrobial stewardship programs in Canada, as I mentioned, act in an advisory role. However, they do have influence on what types of antimicrobials physicians can prescribe, so there's a restriction policy that we have in place, as I mentioned.

In terms of AI, artificial intelligence, its adoption in health care is slow. Certainly there's a lot of opportunity perhaps to automate things that might help clinicians, but that's a work in progress. As an aside, we were planning on having an AI certificate pathway for our trainees at Western who are doing infectious diseases training, and we had strong endorsement from the division chair for that. Certainly that's something that I think we need to look at seriously. AI is here, and it's not going to go away. We have to find ways to integrate it into health care.

**The Chair:** Could you wrap up, please.

**Sameer Elsayed:** Thank you very much.

**The Chair:** Thank you.

I'm going to Mr. Eyolfson for five minutes.

**Doug Eyolfson (Winnipeg West, Lib.):** Thank you, Chair.

Thank you all for coming. This is very useful.

Dr. Wuerz, it's particularly good to see you again. We worked together in ICU through the pandemic. Those were adventurous times, to say the least.

Dr. Wuerz, we were talking about having these guidelines. How do we transmit them in real time to primary care physicians? Primary care physicians take CME and do their journal reading, but as you well know, it's very, very hard to keep up with everything, par-

ticularly in primary care. You also have to know a bit of cardiology, a bit of respiratory, these sorts of things.

What would be the solution to getting these real-time latest practice guidelines out to primary care providers?

**Terry Wuerz:** Madam Chair, I also appreciate the question by the honourable member, whom I know quite well from the work we did through the pandemic.

Yes, I appreciate that the problem of ensuring that antibiotics are used appropriately is multi-faceted and really needs to address very strongly those who use these antibiotics the most, the frontline primary care clinicians.

There are many effective strategies that have been used. I think the key is that it's not just one thing that is needed. One important effort is the publication nationally of guidelines for treatment of common conditions. We have such guidelines, but we really need to bring those guidelines to the clinicians who are working on the front lines. That's where antimicrobial stewardship programs can really play a key role. It's not just about having those guidelines out there in space, because as the member said, these clinicians can be quite busy and not necessarily up to date on the latest guideline that has come out.

An antimicrobial stewardship program will effectively bring that information to the level of the patient and the provider. Then they look at the situation and evaluate it and ask if there is an opportunity to apply appropriate antimicrobial stewardship and improve the treatment of the individual patient. It's at the patient level. It's not manipulative in any way. It's a guidance that's provided by a program and by experts to better deliver the care that is needed right at the ground level.

• (1220)

**Doug Eyolfson:** Thank you for that.

Dr. Elsayed, you talked about this before. You've been asked a couple of questions about it. I've had an interest in this for a while, since I first found out that antibiotics are used in animal husbandry. As you said, these are often given in livestock operations, mostly beef, because they promote growth. The question I have is, how do the farmers access it?

To make an outrageous hypothetical, if I were a teacher and decided I wanted to make my students healthier by distributing antibiotics, I could not obtain them because I would need a physician prescription to do that, and no physician would do that of course. How are the livestock producers getting these antibiotics? Are there veterinarians who are prescribing or approving them for purchase by these producers?

**The Chair:** You have one minute.

**Sameer Elsayed:** Madam Chair, during the COVID-19 pandemic, people were hyped up about getting ivermectin as a supposed therapy for COVID-19. Again, there is controversy about whether it actually works or not, but people were accessing it through animal feedlot stores or through non-conventional routes. They were getting access to these drugs where normally for humans we would have to go through pharmacies or special access programs to get this medication—

**Doug Eyolfson:** Sorry, I apologize for cutting you off. I'm running out of time.

**The Chair:** You have 30 seconds.

**Doug Eyolfson:** This really predates COVID, so the question I'm getting at is, do feed stores sell these antibiotics? How do these operators get these antibiotics? Do they need a prescription from a veterinarian? How do they legally obtain them?

**Sameer Elsayed:** I don't.... That's why I was alluding to pre-COVID, because now I believe there's still a lack of regulation in terms of how farmers can get access to antibiotics. Because I'm not a farmer, I don't know how they are getting access, but I do know that they can get access to these medications far easier than we can in health care, so there needs—

**The Chair:** Could we please wrap up.

**Sameer Elsayed:** Thank you very much.

**The Chair:** Thank you very much.

I'm going to a third round.

I'm going to Mr. Bailey for the Conservatives.

You have five minutes, please.

**Burton Bailey (Red Deer, CPC):** Thank you, Madam Chair.

Dr. Elsayed, you briefly spoke about medical tourism and the number of infections we're seeing coming back to Canada. Should we not, as physicians and dentists, be telling patients about the risks of medical tourism?

**Sameer Elsayed:** Madam Chair, certainly, I do try to emphasize the importance of seeking health care within Canada. Even some of my family members have asked about it. They said they're going to wait forever to get surgery and they could get it more quickly if they went to another country. I told them that their risk of getting a post-operative infection with a drug-resistant organism would be far greater if they went to such-and-such a country than if they got their health care in Canada. Even the United States has a higher incidence of antimicrobial resistance compared to Canada.

I would say Canada is [*Technical difficulty—Editor*] in our health care system to encourage more Canadians—

**Burton Bailey:** Thank you so much.

Dr. Wuerz, we've been seeing a very sharp increase in necrotizing fasciitis. I'm wondering if this is due to an improper initial diagnosis. Do you have any thoughts on that?

• (1225)

**Terry Wuerz:** Necrotizing fasciitis, just for information, is the most severe form of skin soft tissue infection that we see. It can be

rapidly progressive, has a high mortality rate and requires urgent surgical intervention to improve outcomes.

As for why, it is true that we do see cases coming up. For example, in my home province we have a very high incidence rate of necrotizing fasciitis. The reasons underlying that are not entirely clear. This is not necessarily driven by antimicrobial resistance per se, but when we do see infections that are of that nature and severity that are caused by antimicrobial resistant organisms, the results are devastating because we don't have the time to wait days to get the infection under control.

**Burton Bailey:** Thank you.

This leads me to another question and I'd like your thoughts on it.

With some provinces enabling safe injection sites, we're seeing so many more needle injection injuries that require IV antibiotics. When IV antibiotics aren't effective, sometimes it turns into necrotizing fasciitis. We're seeing some of the vulnerable population losing limbs. I heard you speaking about how debridement and amputation are the options.

I am wondering whether it is possible that in the emergency rooms we're misdiagnosing some of the vulnerable people or whether it is just how aggressive necrotizing fasciitis is.

**Terry Wuerz:** I really appreciate that question, because the topic of infections related to injection drug sites is very near and dear to my heart.

I would propose that it's a combination of the factors the member brought forward. We are seeing many infections that are presenting late related to injection drug site infections, and that certainly contributes to the problem. In some cases, I'm sure it has happened that they are vulnerable individuals who have a hard time advocating for their health, so they may have initially been misdiagnosed. This continues to be a major problem that requires prevention as well as good, appropriate and timely access to treatments.

**Burton Bailey:** Thank you, Doctor.

**The Chair:** You have 45 seconds.

**Burton Bailey:** Madam Chair, at this this time, I'd like to move a motion, which was put on notice on Friday, November 28. All members should already have it, in both official languages. Would you like me to read the motion, Madam Chair?

**The Chair:** Is it pertaining to the agenda, the subject that we're dealing with today?

**Burton Bailey:** It was tabled and reads:

That the committee invite the Minister of Health and department officials to appear to testify on the supplementary estimates (B) on December 4, 2025 or December 9, 2025.

**The Chair:** Witnesses, please excuse us while we deal with the motion on the floor.

Does anyone wish to speak to the motion?

Go ahead, Mr. Mazier.

**Dan Mazier:** Madam Chair, can we seek unanimous consent on this? It's been tabled. We all would like to have the minister come in next week.

**The Chair:** Do we have unanimous consent?

**Some hon. members:** Agreed.

(Motion agreed to)

**The Chair:** That has been dealt with, so I'll go to Ms. Jaczek for the Liberals.

**Hon. Helena Jaczek:** Thank you so much, Madam Chair.

Many of the witnesses today talked about national surveillance. There are models. It seems like many recommendations have been made to include other sites for surveillance, such as long-term care, community and so on. I'm all in favour of data, but the next step is stewardship. I would like to dig a bit into that.

We have some data from 2023 that shows there was only a 6.6% decrease in annual antimicrobial prescribing compared to 2019. In other words, presumably, stewardship efforts are having some impact, but it's not exactly a dramatic decrease.

Perhaps, Dr. Wuerz, you could start off by describing what comprises the stewardship program and how you try to avoid the inappropriate use of antibiotics, either the dosage or a particular compound. Presumably, education is key in this, but how do you see this rolling out? How could we make it more effective compared to the rather small decrease that we've seen to date?

• (1230)

**Terry Wuerz:** The honourable member is absolutely right. Antimicrobial stewardship is a program that is designed to improve antibiotic prescribing, getting the right drug to the patient at the right dose and duration. This requires a multi-faceted approach, so it's really a quality improvement program.

We have different tools to address that. Probably the most effective one is something we call audit and feedback. This is where cases where antimicrobials are being used, especially in those cases in the hospital setting where there's really a need to review the antibiotic, the antimicrobial stewardship team, which is a team of pharmacists and physicians, will go to the patient, review the case and apply the most relevant evidence and guidelines to improve the antibiotic prescription. Really, they are offering a recommendation to the treating physician. This has a benefit of not only improving the situation for the patient but also, over time, changing the culture by really bringing that evidence at the level of patient and prescriber. That's one tool. It's called audit and feedback.

Education plays a huge role. That is not enough by itself. We need to have the boots on the ground to provide that antimicrobial stewardship.

**Hon. Helena Jaczek:** Do you see those boots on the ground being comprised of the infection control practitioner who is in the hospital? We're talking about the acute care setting in this instance, of course. In Ontario, we have—or we had—a very strong system of infection control practitioners in each acute care facility. Would they not be vital as part of the team?

**Terry Wuerz:** I agree that infection prevention and control are a vital resource. They are present in hospitals. They have a very strong overlapping role within an antimicrobial stewardship team, but antimicrobial stewardship teams have a slightly different focus. It's really to bring the best antibiotic recommendations to the patient, not just prevention and control. In most cases, an antimicrobial stewardship team is run by pharmacy, whereas IPAC teams are more led by nurses supported by their physician leaders. They're all leaders, but yes, they work together.

**The Chair:** You have one minute.

**Hon. Helena Jaczek:** In the old days, when I practised medicine, which was a long time ago, we used to wait for the Gram stain, the culture, to come back from the lab before we prescribed. Has that gone out the window, so to speak? Patients seem to be requesting antibiotics for whatever ails them. Are we not waiting for at least some lab results?

**Terry Wuerz:** The practice of medicine hasn't changed so drastically since the honourable member has practised. It depends. It depends on the severity of infection and how long we can wait to prescribe an antibiotic. In some cases, we're seeing patients with sepsis or a severe, life-threatening infection where we do need to prescribe an empiric antibiotic before we obtain the culture results, which can take, as you say, a day or more than a day. It really depends. In less dire situations, it's still absolutely recommended to wait for the culture.

**The Chair:** Thank you very much.

I'll now go to the next questioner.

• (1235)

[Translation]

Ms. Larouche, you have the floor for two and a half minutes.

**Andréanne Larouche:** Thank you, Madam Chair.

Mr. Wuerz, do you share the Auditor General's opinion about the lack of data on vulnerable populations in certain geographic areas? How does that impact antimicrobial resistance?

[English]

**Terry Wuerz:** When we speak of vulnerable populations, I think that we do have some further work to do to understand them better and how we can better serve them. The issue is that these populations don't necessarily present early for care. They may be more at risk for infections due to a confluence of factors, including overcrowded housing, shared risk factors such as injection drug use and lack of appropriate sanitation. They are at an increased risk, and they present late, so they see a lot of antibiotics. We know from studies looking at populations that they get more antibiotic use and consequently see more antibiotic resistance. I think this is a key population to focus on when we're thinking about how we help prevent and treat infections and prevent antimicrobial resistance.

[Translation]

**Andréanne Larouche:** You're talking about the link between vulnerable populations and the geographic issue. Some rural populations are underserved, and that has repercussions. What targeted measures should be prioritized for regions facing inequalities in care?

[English]

**Terry Wuerz:** That's an excellent question, Madam Chair.

We need to make sure we're bringing the information not only to the physicians but also to the patients, and at a level everyone understands so we can inform them and make sure they are seeking care and that they know the appropriate actions to take when they do become ill.

**The Chair:** Thank you.

I'll now go to Mr. Mazier for the Conservatives.

You have five minutes, please.

**Dan Mazier:** Thank you, Chair.

I'll cede my time to Mr. Epp.

**The Chair:** Mr. Epp, you have five minutes, please.

**Dave Epp:** Thank you, Madam Chair.

The issue of the state of our NESS and domestic manufacturing of PPE is one I've been wrestling with for a while. I know a number of people have been frustrated by the inability to get answers.

I appreciate the testimony today. I wasn't able to get to all of my questions, so, Madam Chair, arising from the testimony that we have heard, I would like to move a motion.

I know the committee has the authority to compel PHAC and other departments to appear, but I wonder if they want to consider writing a letter so that they have a timely response for the purposes of the study.

Madam Chair, I believe the clerk is circulating this in both languages. I move:

That the committee order the Public Health Agency of Canada, Health Canada, Department of National Defence, and the Department of Public Services and Procurement to answer the following questions, and report back to the committee.

Regarding the National Emergency Strategic Stockpile (NESS) and the procurement of personal protective equipment (PPE) from 2019 to the present:

1. Which companies were awarded contracts under the 2019–2020 Standing Offer for the supply of PPE to the NESS, and what was the total dollar value of the contracts awarded to each company?

2. How many units of PPE were purchased by the federal government for the NESS under the 2019-2020 Standing Offer between March 2020 and October 2025, separately identified by year and supplier?

3. How much money, in total, was spent—

**The Chair:** Mr. Epp, I'm sorry to cut you off, but not everyone has this motion in English and French.

**Dave Epp:** I can pull up the motion. It should be in your inbox.

**The Chair:** It's only in English, I'm told by the clerk. She does not have it in French.

**Dave Epp:** Okay, it is coming in French.

Do you want me to continue reading or pause until everyone has it in French?

**The Chair:** Perhaps we could suspend for a bit until we get it so that everyone can look at it before they debate it.

Thank you.

We are suspended.

• (1235) \_\_\_\_\_ (Pause) \_\_\_\_\_

• (1300)

**The Chair:** The meeting is resumed.

Go ahead, Madam Larouche.

[Translation]

**Andréanne Larouche:** Madam Chair, we agree on the questions asked. Only one witness will be appearing before the committee, so we have to make sure we get answers from the other witnesses. To avoid delaying the study, I would give them two weeks to respond to the letter and to the questions. I therefore propose an amendment to request those answers and, at the end, I recommend we set a specific deadline of two weeks to provide those answers.

[English]

**The Chair:** Could you please read your amendment, Madam Larouche?

[Translation]

**Andréanne Larouche:** We're proposing a two-week time frame to get the answers and avoid delaying the study.

• (1305)

[English]

**Dave Epp:** Madam Chair, may I?

**The Chair:** Hold on for a second.

We have an amendment.

Madam Larouche, your amendment just says to push back on the two weeks. Is that your amendment?

I'm sorry, Mr. Epp. Madam Larouche has the floor.

[*Translation*]

**Andréanne Larouche:** After “the following questions, and report back to the committee”, we would add the 14 days.

[*English*]

**The Chair:** You're suggesting to report back within two weeks.

[*Translation*]

**Andréanne Larouche:** Yes.

[*English*]

**The Chair:** We have an amendment on the floor, which will add “to report back within two weeks”.

Are there any names for speaking to the amendment?

Mr. Epp, would you like to speak to the amendment?

**Dave Epp:** I just want to seek clarity. I have not read the whole motion into the record. It has been circulated. Has it been considered duly moved?

**The Chair:** I think it's been considered duly moved.

**Dave Epp:** If it's been duly moved, yes, I would consider that to be a friendly amendment.

**The Chair:** Then speaking to the amendment, is anyone for or against it?

I get a sense, unless you want me to record a vote, that the amendment passes.

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

**The Chair:** We now go to the motion as amended.

Is there any debate or discussion on the motion as amended?

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

**The Chair:** We have spent 22 minutes suspended. We began the meeting four minutes late. We have one more person to speak and that would be Ms. Sidhu.

We'll give Ms. Sidhu the opportunity to ask her questions.

**Sonia Sidhu:** Thank you again to all the witnesses.

My question is for Dr. Wuerz about the use of antibiotics in the agriculture sector. It's also for Dr. Elsayed from Western.

I want to hear from both of you on how we can regulate the agriculture industry.

**Terry Wuerz:** Madam Chair, I'll note that my area of expertise is in human health, not in animal health. However, it is true that the problem of antimicrobial resistance is a multi-faceted one. If we want to address the issue effectively, it involves primarily antibiotic use in humans, but we also need to address it in the use in animals and in the environment as well.

Those are the three pillars that Canada's AMR action plan from 2023 mentioned and addressed. The issue I'll mention again is that there is not a lack of a plan, but a lack of implementation, timelines and indicators.

**Sonia Sidhu:** With that, I just want to raise another point. Infection prevention is one of the strongest tools we have to reduce AMR. We talked about needles. If there are safe injection sites or if there's control of drugs and needles, it also decreases infections.

Do you agree with that, Dr. Wuerz?

**Terry Wuerz:** The question is whether safe injection sites may reduce the risk of drug injection infections. The answer to that question is yes, I think so.

The issue is that many times injections occur in very unsanitary conditions and sometimes with reused equipment. Any effort that can be put towards harm reduction in reducing these types of infections and preventing them in the first place is going to be an effective one for reducing morbidity and mortality related to those vulnerable individuals we spoke about earlier.

• (1310)

**Sonia Sidhu:** What type of federal public awareness efforts would most effectively support infection prevention?

**Terry Wuerz:** I believe the issue is that we need more implementation across the country. For that, I would turn to the federal government to basically create standards that need to be applied across jurisdictions to ensure that we don't see major differences in antimicrobial programs and antimicrobial use from province to province. The federal government plays an important role in providing those standards and also in ensuring that they're upheld.

**Sonia Sidhu:** My next question is for Dr. Dhama.

Dr. Dhama, you talked about the pan-Canadian action plan. How can better integration among pharmacy systems, prescribers and surveillance programs improve stewardship and patient safety?

**Rita Dhama:** One of the opportunities we have is to better integrate some of our health information systems. Within a hospital setting, all health care practitioners are going to have this ability to see the patient's lab values or the patient's medication record. They'll have access to notes from physicians or from other health care professionals taking care of the patient. You can see the fulsome health care plan. Where that breaks down is once the patient leaves the four walls of a hospital. Again, when we talk about long-term care or about primary care, there's certainly that opportunity to improve the information sharing and the communication between the prescribers and the pharmacists as well as to integrate better opportunities for—

**The Chair:** You have 20 seconds.

**Rita Dhama:** —handing over the care plan for the patient.

Oftentimes, pharmacists in the community are the ones who have ongoing contact with patients. They can help monitor for adverse reactions and for opportunities where the person needs to go back to see a physician to get either alternate therapy or lengthened therapy.

**The Chair:** Thank you, Ms. Sidhu.

I would like to thank the witnesses very much for taking the time.

I'm sorry you had to wait for so long.

**Dan Mazier:** I have a point of order.

**The Chair:** Yes, Mr. Mazier.

**Dan Mazier:** If we have a few minutes, since it's the Bloc's study, could we give her two and a half more minutes, another round?

**The Chair:** Well, this is a round in which Ms. Larouche had two and a half minutes already.

**Dan Mazier:** Yes, but could we just extend the round, if the committee is in agreement with it?

**The Chair:** Is the committee in agreement to give Madam Larouche another two and a half minutes?

**Some hon. members:** Agreed.

**The Chair:** Thank you.

Madam Larouche, you have two and a half minutes.

[*Translation*]

**Andréanne Larouche:** Thank you very much, Madam Chair.

This study reminds me of my volunteer work with an organization that worked to prevent healthcare-acquired infections. We toured with the *Lave tes mains*, or wash your hands, campaign to explain to people how important different rules and standards for hand washing are in preventing infections. We raised awareness, even in hospitals. This reminds me of all that, and how relevant that campaign is to this study.

Dr. Stinson, what are the most significant obstacles to consistently applying prevention practices in various settings, that is to say in hospitals, long-term care facilities and clinics?

**Kevin Stinson:** Thank you for the question. I will answer in English.

[*English*]

In terms of overall barriers, you're certainly right. Hand hygiene is probably one of the most consistently significant methods of pre-

venting transmission of infectious disease and antimicrobial resistant organisms in all health settings.

One of the barriers that we often see to implementing that is overall resources. I believe it was Dr. Elsayed who alluded to the challenges we see in health care right now, with over census, too many patients and resource limitations. When you compound all of those factors together, it's easy to start saying, "Well, I could just take a shortcut here. I could take a shortcut there. I don't need to wash my hands. I don't need to worry about my PPE." That could be translated to antimicrobial stewardship overall, and "I can just kind of cut out and simplify my antimicrobial ordering practices for simplicity's sake." Ultimately, what it comes down to is the overall resources of the entirety of our health care system, not just in personnel, not just in physical infrastructure, but everything.

• (1315)

[*Translation*]

**Andréanne Larouche:** I have 15 seconds left, so I'll ask a quick question. How important are health transfers in providing more financial resources?

[*English*]

**The Chair:** You have 11 seconds, Madam Larouche.

[*Translation*]

**Andréanne Larouche:** I asked my question: How important is it to increase health transfers to provide more resources?

[*English*]

**The Chair:** I will now adjourn the meeting, as it is well after one o'clock.





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**Tuesday, December 2, 2025**

Published under the authority of the Speaker of  
the House of Commons

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