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(1100)

[*English*]

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

Welcome to meeting number 62 of the health committee.

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

I'll introduce our guests and thank you very much for coming. Dr. Andrew Morris is chair of the antimicrobial stewardship and resistance committee, Association of Medical Microbiology and Infectious Disease of Canada.

We have, from the Canadian Nurses Association, Karey Shuhendler, policy advisor, policy advocacy and strategy; and we also have Yoshiko Nakamachi, an antimicrobial resistance nursing expert. Thank you for coming.

From the Canadian Pharmacists Association we have Shelita Dattani, director of practice development and knowledge translation.

From the Royal College of Physicians and Surgeons, we have Dr. Michael Routledge, medical officer of health,

Southern Health Regional Health Authority.

We're going to start with the Association of Medical Microbiology and Infectious Disease, Dr. Morris, 10 minutes.

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

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

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

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

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

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

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

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

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

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

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

When I started practising medicine the only common AMR acronym in our lexicon was MRSA, methicillin-resistant Staph aureus. Today that list also includes KPC, ESBL, NDM-1, VRE, CDI, and the list goes on. These all cost the health care system billions of dollars. It is juxtaposed with the over $1 billion we spend on prescription antibiotics in Canada, of which about half of the use is unnecessary.

More importantly, it is an overall threat to national security and threatens Canadians in a manner greater than violence and accidents combined.

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

(1105)

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

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

For starters, convene and fund a national network to coordinate stewardship, hereby known as AMS Canada; nominate executive leads on AMS at the federal, provincial, and territorial levels for strategic planning and implementation; enhance accreditation for AMS; support and scale up core operations in hospital-based AMS; enhance awareness of AMR and AMS among prescribers and public; establish an AMS or antimicrobial stewardship research and development fund; develop and support core data sets in AMU surveillance—antimicrobial utilization surveillance; incent community prescribers using audit and feedback mechanisms; develop national guidelines for antimicrobial prescribing and mechanisms to promote adoption; and finally, develop a network of centres of excellence in knowledge mobilization for AMS.

That was one year ago, as I mentioned. What has happened? The same thing that happened with the 2004 report “National Action Plan to Combat Antimicrobial Resistance”, and the 2009 report following pan-Canadian consultation by the since-defunded Canadian Committee for Antimicrobial Resistance. In 13 years, we have three national reports on antimicrobial resistance, and the collective response from the federal government remains a tacit one. In fact, the Public Health Agency has all but eliminated any anticipated funding towards antimicrobial stewardship and surveillance for the upcoming year. “Suspended” is the term we have been given.

This pales in comparison to the United States, which spends over $1 billion annually to combat antimicrobial resistance with an effort that includes Defense, Justice, and Homeland Security, among other departments.

The United Kingdom has equally provided strong leadership and effort with their chief medical officer of health, Dame Sally Davies, perhaps the strongest world advocate on the subject.

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

I could go on, but suffice it to say that in Canada antimicrobial resistance is not being sufficiently addressed. This is reinforced by our own Auditor General who, two years ago, concluded that the Public Health Agency of Canada and Health Canada have not fulfilled key responsibilities to mitigate the public health risks posed by the emergence and spread of antimicrobial resistance in Canada. The Auditor General stated that the Public Health Agency of Canada has not determined how it will address the weaknesses it has identified in its collection, analysis, and dissemination of

surveillance information on antimicrobial resistance and use. The agency has taken some steps to promote prudent antimicrobial use in humans, such as developing and disseminating guidelines for health professionals, but has identified the need for more guidelines.

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

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

Thank you for your attention.

(1110)

The Chair: Thank you. You pack a lot into 10 minutes. Most impressive.

We'll move on to the Canadian Nurses Association.

Karey.

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

Good morning, Mr. Chair, and members of the committee.

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

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

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

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

The director-general of the WHO has referred to AMR as a “slow moving disaster”, one of the most serious threats to human health and safety. The WHO has also warned that AMR is putting the gains of the millennium development goals at risk and it endangers achievement of the sustainable development goals. AMR is an issue that requires action by

all areas and disciplines in health.

In it's 2017 position statement on AMR, the International Council of Nurses notes:

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

Nurses contribute to assessment and diagnoses of infections, they administer and may prescribe antimicrobials, they monitor outcomes and report side effects, provide vaccinations and educate patients, families and communities.

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

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

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

CNA's efforts in this area including membership and participation on the antimicrobial stewardship or AMS Canada Steering Committee, and engaging in the Canadian Roundtable on AMS to develop a Canadian multidisciplinary, multisectoral action plan on antimicrobial stewardship.

We are also active participants in the federal/provincial/territorial AMR stewardship task team to develop a pan-Canadian framework and action plan. In addition, through partnering with Choosing Wisely Canada, a national program to engage clinicians and patients in conversations to reduce overuse, CNA has developed a broad list of nursing recommendations to reduce the use of tests, treatments and interventions that may lack benefit or cause harm. Several of these recommendations advance the AMS agenda, including recommendations to reduce inappropriate or unnecessary use of antimicrobials. CNA is planning to release a speciality Choosing Wisely nursing list, in partnership with Infection, Prevention and Control Canada. This list includes recommendations to reduce the use of interventions that can lead to infection, reduce inappropriate laboratory testing which can lead to unnecessary use of antimicrobials, and stewardship recommendations focused on reducing inappropriate antimicrobial use.

(1115)

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

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

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

Our second recommendation urges the federal government to commit to providing significant funding over the next

five years to support scaling up of antimicrobial stewardship programs across acute care and community-based settings in the provinces and territories, conditional on an accountability framework, and that the federal government support the role of nurses in antimicrobial use, resistance, and stewardship.

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

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

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

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

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

Thank you.

(1120)

The Chair: Thank you very much.

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

Shelita Dattani (Director, Practice Development and Knowledge Translation, Canadian Pharmacists Association): Good morning everyone, and thank you for the opportunity to be here today. My name is Shelita Dattani and I'm the Director of Practice Development and Knowledge Translation at the Canadian Pharmacists Association, which is the national voice of Canada's 42,000 pharmacists. I'm also a practising hospital and community pharmacist and have significant experience leading and participating in antimicrobial stewardship initiatives in the hospital setting.

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

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

I want to talk to you today about antimicrobial stewardship and the role of the pharmacist. As others have said, stewardship is a team sport and our collective goal in antimicrobial stewardship is ensuring that patients get the right antibiotics when they need them, and only when they need them. As the medication experts, pharmacists are fundamental to antimicrobial stewardship. Hospital pharmacists throughout this country have demonstrated leadership in antimicrobial stewardship activities and programs for several years now. Just as I spent much of my time in hospital practice ensuring that patients were receiving the right antibiotics and only if they needed them, I work with my primary

care colleagues now to do the same when I practise at the neighbourhood pharmacy. So, pharmacists can act as stewards throughout the continuum of care, as other professions can. We work in hospital settings, long-term care settings, primary care teams, public health and the area that I will predominantly focus on today, which is community pharmacy.

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

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

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

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

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

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

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

(1125)

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

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

Pharmacists can also help support their physician colleagues that use delayed prescribing, which is a debatable

practice. So if a patient gets a prescription from their doctor and is instructed to start antibiotics if symptoms do not improve after a specified time, I can reinforce symptom management with my patient to ensure that we don't jump to antibiotics too quickly. I can counsel my patient on when to follow-up with her prescriber. If my patients do end up needing antibiotics, I will talk to them in detail about benefits, but also the other things that they may not be thinking about, the adverse effects and other unintended consequences that have been described here today.

Rapid strep tests are also now offered in some pharmacies. Pharmacists can administer these tests and can intervene immediately, either through prescribing or recommending antibiotics or over the counter treatments for viral illnesses, as appropriate. Expanding these services would further relieve pressure on the health care system if patients are able to avoid emergency departments or urgent care clinics.

A UK demonstration study showed that 49% of patients would have sought care from a family doctor if strep tests were not accessible and available in community pharmacies that are the health care hubs of their communities.

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

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

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

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

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

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

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

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

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

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

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

Thank you very much.

The Chair: Thank you very much.

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

(1130)

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

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

Advancing the AMR agenda can be difficult because, even though it is an extremely important and impactful public/population health issue, it is one that is slow moving and doesn't tend to grab headlines. You've heard a couple of witnesses already talk about the idea that it's slow moving and referred to often as a slow-moving tsunami. It's easily pushed to the corner of desks for the urgent health issues of the day. If AMR can be positioned, going forward, as the critically important issue that it is, and if the national and regional structures that are working on this can continue to be supported and strengthened, we will be able to fully utilize all the knowledge and resources that exist in a way that supports this work across all of Canada.

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

Canada has, and has had in the past, many examples of local pockets of excellent work on antimicrobial resistance, the “do bugs need drugs program” in B.C. and Alberta being one example. What has primarily been lacking is a robust structure that can coordinate, disseminate, and support these leading practices across all health care organizations and professionals in Canada. The creation over the past few years of the 2014 federal framework and the current FPT steering process, combined with the efforts of organizations like Health Care Canada and the NCCID, have positioned Canada well to take the necessary next steps. The key going forward will be to ensure these processes are reported and monitored in order to ensure that antimicrobial stewardship is receiving the attention and work it warrants across the country.

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

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

Ms. Sidhu.

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

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

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

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

Shelita Dattani: Thanks for your question. As I alluded to in my comments, pharmacists are currently engaging in lots of different opportunities, whether it's counselling patients, whether it's public health and health promotion, or whether it's discussions during immunizations. Pharmacists can definitely have a more impactful role if they're able to actually intervene on patients' therapy, adapt prescriptions, adapt durations of therapy, and prescribe for simple, uncomplicated types of infections. This is happening in a couple of provinces throughout the country but is not consistent, and doesn't completely make sense to me when I have the same knowledge, skills, and judgment as my colleague in New Brunswick or Alberta who is able to exercise this and act as an antimicrobial steward and I can't. Consideration of that harmonizing practice across the country to enable pharmacists to practise to that expanded scope is a key solution.

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

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

If we look at the basic elements of research, it has to start with an understanding of our current state. We don't really have a very good understanding of our current state in terms of antimicrobial resistance, nor in terms of antimicrobial use. I think the first efforts would have to be foundational efforts toward ensuring that we have good data.

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

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

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

(1135)

Ms. Sonia Sidhu: Thank you.

I want to ask the nurses associations, in your views how knowledgeable are Canadians of AMR? I heard testimony that $1 billion is being spent on antibiotics in Canada. Last week we heard of 95% use in communities.

Do you think we need more public awareness? How can we do more public awareness? What kind of steps need to be

taken?

Ms. Karey Shuhendler: Thank yoo for your question.

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

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

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

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

Ms. Sonia Sidhu: Do I have more time?

The Chair: You have 44 seconds.

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

Dr. Andrew Morris: Thanks for the question.

Some of that is a bit out of scope from my area of expertise. What I can tell you is that many of the antimicrobials that are used for animals are not of medical interest or significance. Of those that are, almost certainly a reduction in use of those antimicrobials will benefit the Canadians population.

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

(1140)

The Chair: Time's up. Ms. Harder, seven minutes.

Ms. Rachael Harder (Lethbridge, CPC): Awesome.

My first question is for Mr. Morris. My question is this, we're talking about antimicrobial resistance. Let's say we do nothing, theoretically, let's just say we leave things as they are, and things continue to progress. Paint a picture of what this is going to look like in 50 years from now.

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

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

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

If we can't use antibiotics for a simple surgery like that, then 1 in 20 people who are getting hips, rather than 1 in 100 people who are getting hips, are going to get infections, and require [*Inaudible*]. Cesarean sections, same thing. The risks are even higher. Abdominal surgeries. The list goes on.

Transplantation medicine for solid organ transplantation, the backbone of that is antimicrobials. It requires a very broad team to be involved, but the backbone involved is antimicrobials.

Supportive care for cancer chemotherapy, absolutely requires antimicrobials. If you have leukemia and you're receiving chemotherapy, you have an almost certainty that you're going to require broad-spectrum antimicrobials for weeks.

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

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

My next question here is also for you. It's a question with regard to the Auditor General's report. In 2015, he came out with the antimicrobial resistance report 1. It was identified in it that another six guidelines were needed moving forward, that's my understanding, for specific antimicrobial resistant infections.

As I believe you noted in your testimony, that was put on hold. Those guidelines actually haven't been further developed. Can you comment on that?

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

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

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

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

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

(1145)

Ms. Rachael Harder: Okay. Thank you.

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

We'll start over here and maybe just work across. What has your engagement been?

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

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

Ms. Rachael Harder: Thank you.

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

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

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

Ms. Rachael Harder: Ms. Dattani.

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

Ms. Rachael Harder: Mr. Morris.

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

The Chair: Time is up.

Mr. Davies.

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

Thank you, to all the witnesses, for being here.

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

Dr. Andrew Morris: Thank you for the question.

I'm not sure how to put a number on it. I'm not somebody who really wants to scare. It's very important.

If we're talking about how much it will affect Canadians' lives in the next five to ten years, I'm going to say it's going

to substantially and it's almost certainly going to affect, if we don't do anything, Canadians' lives. In fact, it may involve Canadians' lives despite us doing something about it.

The world is small. We not only have to deal with antimicrobial resistance that we breed in Canada, but there are also the ones that we import here through travel, immigration, agriculture, trade, etc.

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

Dr. Andrew Morris: It requires urgent attention.

Mr. Don Davies: Thank you.

Now I want to get a handle on the causes. Can anybody on the panel tell me what the contributors are to antimicrobial resistance, and list them in the order of priority for me?

Dr. Andrew Morris: I'll start.

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

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

We, as humans, don't tend to have many fungi in or on us, but we have many bacteria. When we do get exposed to fungi or the antibiotics that they produce, we use them to kill bacteria that cause us problems.

Some of the resistance occurs out in the environment and comes to us. But there really is no other major cause of antimicrobial resistance other than bacteria being exposed to antibiotics.

(1150)

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

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

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

Mr. Don Davies: I see.

Dr. Routledge, I'm interested if you could explain how the prescribing practices of physicians, and the prescribing practices of antimicrobials are regulated, reported, or enforced.

Dr. Michael Routledge: How the prescribing practices are regulated? I'll take a stab at that and maybe Andrew can add, as well.

I would say that the prescribing per se isn't regulated per se. Overall practice is what would be regulated. Certain types of prescriptions would be more regulated, for example, narcotic prescriptions have a regulation to them.

Antibiotics don't have those, generally speaking. I think probably where you're going is prescribing of antibiotics generally speaking isn't specifically regulated.

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

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

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

If I could just add, you asked the question about agricultural versus human use. I would basically echo what Andrew said, but I think it's really important just that idea that both really are important. Depending on what you read, some sources will say that it's agricultural use predominantly, others will say human use in terms of what the major causes are, but the reality is both are significantly important. It really is important and critical to address both spheres.

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

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

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

(1155)

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

To answer your question with regard to there being enough education for these health care professionals, I agree, it's a team sport, but up until now, nurses have been largely ignored and under-utilized and have not received the same type of training. Again, I think there definitely needs to be more training for both pharmacists and physicians, but in nursing there is almost no training available in their degrees, when they're doing their nursing degrees. Also in the hospital setting and the community setting, there aren't educational programs for nursing or targeted at nursing, because the triggers for antimicrobial use or monitoring is very different for nursing than it is for pharmacists and physicians. The educational programs need to be specific to the profession. It's a team sport and we all play different positions on the team.

The Chair: Okay, time's up.

Mr. Kang.

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

My questions are for Shelita Dattani. The overuse, or misuse, of antimicrobials has arisen from different causes, including over prescribing by doctors, failure by patients to complete a course of antibiotics as prescribed, and the medical and non-medical use of antibiotics. According to the brief, Antimicrobial Stewardship Canada, there are 23

million antimicrobial prescriptions written every year. In the brief, it says 30% to 50% of the prescriptions are not necessary. It is costing lots of money, $70 million to $80 million. It boggles my mind when I see this is what's happening.

You said your organization has done something, like education. Have you worked with other health care providers, like CMA or the Royal College of Physicians and Surgeons of Canada? What steps have you taken to correct this over-prescribing, which is not necessary?

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

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

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

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

Shelita Dattani: In terms of our organization specifically, we participate and relay the messages of campaigns, like “Do Bugs Need Drugs” and “Choosing Wisely” to help.

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

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

(1200)

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

Mr. Darshan Singh Kang: My next question is for you. The upfront cost here is maybe 30% or 50% of $70 million to $80 million for unnecessary prescriptions. These are prescribed and patients take them. Are there any side effects? What kind of cost is there to society for this?

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

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

Shelita Dattani: I'll start, and then I'll encourage you to join in.

In terms of costs—and Andrew's going to be able to, I think, answer this question much more effectively than I am—and I'll give you an example, the second-most common reason for a drug-related adverse event when a patient presents to an emergency department is an antibiotic-related adverse event. The costs, and the health system costs associated with that, are significant. Unintended consequences, like clostridium difficile, the superinfection that can arise with overuse of antibiotics, has significant costs. I can't necessarily put numbers to those, I don't have those off the top of my head, I'm sure Andrew can expand, but those are two examples that I'd offer you.

Mr. Darshan Singh Kang: And Dr. Morris.

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

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

The costs are in lives.

Mr. Darshan Singh Kang: Thank you.

According to the World Bank—

The Chair: Very quickly.

Mr. Darshan Singh Kang: Very quickly, okay—they are talking about trillions of dollars if we don't do anything about this microbial resistance. To what extent has your organization been engaged in the development of the federal government's pan-Canadian framework on this?

Dr. Andrew Morris: I chair the Antimicrobial Stewardship and Resistance Committee. That committee over the past year has developed and disseminated tools primarily targeting long-term care facilities initially around unnecessary antibiotics for patients—

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

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

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

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

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

(1205)

The Chair: Okay, we're done.

Mr. Darshan Singh Kang: Thank you.

The Chair: We've started our five-minute sessions now.

Dr. Carrie, five minutes.

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

I tell you, the more I read about this, I kind of get worried. It seems like humankind may only have, what, 70 or 80 years where these drugs are effective, and they have been game changers.

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

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

I think, Dr. Morris, you brought up the opioid crisis. Here, at the federal level, last year we brought the topic up, we got experts in, and all this stuff, and what's happened in Canada? This past year it's more prescriptions instead of less.

It's kind of like you're here, this is a federal committee, we want to hear from you. What should the federal government do?

Dr. Morris, should the federal government be using of a more of a heavy stick here? I think it was David Cameron who called “on the governments of the richest countries...to mandate now that by 2020, all antibiotic prescriptions will need to be informed by up-to-date surveillance information and a rapid diagnostic test wherever one exists”.

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

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

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

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

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

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

Mr. Colin Carrie: I appreciate the answer, and I appreciate your trying to be brief, but I think I'm almost over four minutes out of my five minutes, but with a comment, there are huge challenges in Canada and with the provincial jurisdiction—you talk about leadership. Have you brought this to the Council of the Federation because I'll give you one word: Quebec. With your national association sometimes there seems to be some protection when you get provinces and territories together of who should be doing what. Have you brought this to the Council of the Federation to see if you can get agreement across provinces and territories because that seems to be a block.

(1210)

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

Mr. Colin Carrie: Okay, I think some of other organizations are, but I see my time is out, but, Mr. Chair, I note after we're going to be talking about the potential cannabis bill and I just hope we can do that publicly instead of in camera.

The Chair: Okay, now we go to Dr. Eyolfson.

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

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

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

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

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

What is missing right now is that providers have heard this for a long time, so I think all physicians—and I'm going to say, other health care professionals, too—know about antimicrobial resistance, and they know that they should be following guidelines. I, personally, think the challenge is that our health care organizations in this country haven't taken this on.

In terms of national leadership, Accreditation Canada has really moved that forward by introducing this ROP, which means that health care CEOs across this country have to care about this now, whereas before they didn't.

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

Mr. Doug Eyolfson: Thank you.

Dr. Morris, I was actually very interested in what you said about the lack of a role in failure to complete a course of antibiotics because that was one of the things I was taught in residency, that you should use antibiotics like azithromycin that have a shorter course because they're more likely to complete, and less resistance, and how we find out. I say that's

news to me that it is not actually an issue, so that was very interesting.

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

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

Dr. Andrew Morris: Thank you for the question.

I do a fair amount of work personally with emergency physicians in LHIN, my local health integration network. It's really an issue of knowledge translation, so emergency physicians are front line physicians and as you mentioned, increasingly they play a role in primary care, not so much preventative care, but primary care. I don't see it much different from any other aspect of the health care system in terms of wise use of antimicrobials.

We need to put systems in place, we need to have tools available to the prescribers so that they make the right decisions and it's easy to make the right decisions and very difficult to make the wrong decisions.

(1215)

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

Thank you.

The Chair: Time is up. Thank you very much.

Now we go to Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): How much time do I have, Mr. Chair.

The Chair: You have five minutes.

Mr. Len Webber: Thank you.

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

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

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

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

I do want to share a story of my experience that I had. What most politicians experience on a daily basis is meeting people and shaking hands. About three years ago, after shaking hands with about 200 people at an event went home to a sore wrist. I woke up at three in the morning with a hand about twice as large. I went to emergency where they basically cut my hand open and took blood samples. Of course, I had an infection from a small cut I had in my finger that apparently I got shaking hands. This led to many levels of antibiotics that I went through. It led to two months of carrying an antibiotic pump on my side and a week in the hospital before that talking about perhaps amputation, which

scared the heck out of me as well. All because of shaking hands and getting infected. I do warn everyone to continually wash their hands. I know that is part of the education program, and has been.

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

The Chair: Absolutely.

Mr. Len Webber: It's out in the hall.

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

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

Any comments on that at all about where you are with education?

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

Boy, this is difficult, trying to get—

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

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

Much of Do Bugs Need Drugs? is a collaborative effort. A colleague of ours who presented last week, Kim Durera, is a nurse and she had said at the outset of delivering those programs they were nurse-delivered in communities. Now they're also delivered by med students and pharmacy students, and it's a very collaborative effort. Really, the shift to public education has to start with health care providers.

Of course, being from the nursing association, I'd just highlight that sometimes nurses are the only health care providers in a community or in a setting. We appreciate the opportunity to respond to that because we are sometimes people's first point of contact with the health care system. We have a role here in making sure that people are aware to prevent inflections but also judiciously use antibiotics.

(1220)

The Chair: Thank you, Mr. Webber, for the excellent questions. Time's up.

Mr. Oliver.

Mr. John Oliver (Oakville, Lib.): Thanks very much for being here today ans for your testimony.

I got a bit confused listening to this. I had always thought AMR was about a pathogen that for various reasons becomes resistant and then people who are at risk to that pathogen have difficulty treating. I kind o f heard int he testimony, particular, Mr. Morris, your comment that AMR is about ongoing exposure to antibiotics.

Are there situations where people, individuals become resistant? Is it more about a pathogen that's resistant that then becomes transmitted, or is it about individuals becoming more AMR because of their antibiotic use?

Dr. Andrew Morris: Thank you for that question and allowing me to clarify. People don't become in and of themselves resistant. It's somewhat of a metaphysical kind of question because we are to some degree not only what we traditionally think of ourselves, but the organisms that are in and on us as well, and we each have our own bacterial fingerprint. So the person doesn't become resistant. It's the pathogens that for many people don't cause any problems that develop resistance and may be passed on from person to person or animal to person or the other way around, and when those take hold and cause disease that's when we have a clinical problem. People in and of themselves don't characteristically develop resistance; it's the bacteria, it's the pathogen, and those can be transferred onward.

Mr. John Oliver: Thanks for that.

There were two recommendations, I think, from the Canadian Nurses Association and I heard a number of strategies from the pharmacy group. For the committee—we will be issuing a report—are there any other recommendations? We know there's a new national pan-Canadian framework coming out. There are the 10 recommendations in the action plan that's there. Is there anything else that you recommend we'd be flagging to the minister and to the government to expedite or improve our response to AMR?

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

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

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

If I could just emphasize, in the U.K. their chief medical officer of health, Dr. Davies, issued a letter to all family physicians who were outliers in terms of their antimicrobial prescribing. It was actually a trial so half got the letter, half didn't. There was a substantial reduction in antibiotic prescribing after she sent the letter, and it's because she's a recognizable point person. I think you would find it very difficult for anyone in Canada to identify.... I know this committee has been interested in opioids. My guess is you'd be hard-pressed to find a national leader or point person for opioids, and I'm going to say the same thing for antimicrobial resistance which, I'm going to argue, is more complex because it goes outside of humans and there are so many other reasons why it's probably even more complex and opioids is already a very complex problem. You really do need a point person who will see the big picture and oversee and lead something like this.

(1225)

Mr. John Oliver: Are there any other thoughts on recommendations or on that leadership point?

Dr. Michael Routledge: I would echo the leadership point. I'll make another comment sort of along the lines of what's been said before on this topic. I just want to take you back. In 2004, we had SARS, and we developed a lot of plans for SARS and then SARS went away and we stopped thinking about it, and then a pandemic hit and people started pulling their SARS plans off the shelves

But nobody was really ready because we'd kind forgotten about it because it's easy to forget about because all kinds of other things come up. We need to replace hips and knees, we need to get MRIs done and things like that.

We need to have ongoing eyes on this. I spent four years as the chief public health officer in Manitoba. I sat at the FPT tables. It's really critical for those tables, and I'm going to say in this case for the FPT steering committee. You mentioned the council of the federation and there are health ministers' table, the deputy ministers' tables. They need to be demanding action from that group, seeing it on a regular basis.

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

Mr. Don Davies: Thank you.

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

Ms. Yoshiko Nakamachi: Yes, absolutely. I know that the question was what will our health care system look like 50 years from now, but we're already seeing patients who have multi-drug resistant organisms experiencing that.

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

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

Mr. Don Davies: Thank you.

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

Dr. Andrew Morris: No.

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

Dr. Andrew Morris: Sorry, It didn't start until for stewardship.

Mr. Don Davies: For stewardship, sorry.

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

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

Dr. Andrew Morris: In terms of have things changed? I think things have in terms of intense change somewhat. We have this federal framework and there's been work in terms of developing policy and having FPT partners signing off on this.

I consider that a move forward in terms of addressing AMR. There's been increasing money to CAHR to address a variety of different research priorities that CAHR has around AMR. I think there's some progress there and that includes also they're participating in the joint programatic initiative on AMR, which is an international effort.

In terms of what's needed for understanding and having better data, a better repository of information, it's going to have to be almost certainly something that's staged in nature and it will have to be a ramp-up. You start off in my mind with understanding existing data sets and validating them to make sure that what they're supposedly saying, they are saying. A lot of the data in this is actually from their proprietary information that the Canadian government doesn't even own

Then on top of that you need to start off with probably the easiest systems to put in place would be understanding use in hospitals and then expanding to long-term care and thereafter in provinces with community practices as well. You need standards.

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

(1230)

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

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

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

Ms. Nakamachi, you were talking about a kindergarten. Well, you need to educate the other end of the spectrum as well. That's how far we have to go, but this process will help.

Things move very incrementally here, but they do work and the system does work and your part of it. I want to thank you very much for your contributions, because they were very effective. So that's it.

Yes, Dr. Carrie.

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

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

The Chair: I can.

Mr. Davies.

Mr. Don Davies: I'd like to second that, and in fact, I pulled the blues and Hansard from Wednesday, February 17, 2016, when we first discussed this committee when it would be appropriate to go in camera or not. Members may remember that I had a motion that would explicitly say that committee business was conducted in public at this committee other than when we were considering draft reports or when it was necessary to discuss witnesses' evidence, or names in a free and open way, or for confidential or personal matters. The consideration of committee business should always be public.

At that time, Mr. Chair, you very generously reached out and stated your very clear position that that would be the general thrust of this committee. Now obviously the general description of the dates and subject of the study on the cannabis bill doesn't fall within any of those parameters where we discussed it would be appropriate to go in camera. I noticed there are members of the media here.

The cannabis legislation was a major policy during the last federal election, and there should be no reason whatsoever that the public can't listen to our different views on how we choose to engage public input into this committee. Of course, once we get into the study and we discuss the witnesses, who they may be, that of course, is appropriately in camera, but at this point, it's not appropriate to go in camera and I would ask that you have this portion of the meeting public.

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

Mr. Don Davies: Mr. Chair, that would be fine if we go in camera for that portion, but I'm suggesting and I'm supporting [*Inaudible*]

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

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

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

Ms. Rachael Harder: Thank you.

It brings me some solace that Mr. Oliver agrees with this. It is certainly very important that this stays public. The cannabis bill is very important to the Canadian public and they do need to understand how this committee plans on studying this piece of legislation.

(1235)

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

Dr. Carrie, you're on the list.

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

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

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

Mr. Len Webber: Just some clarification on a comment you made about when we are in camera. You mentioned the letter for Lyme, if we get to it. Are you referring to if we get to preparing one at all?

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

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

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

Dr. Eyolfson?

(Motion agreed to)

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

The Chair: All right, all members have a copy of the budget for our antimicrobial resistance study. I'd just like to....Is there any debate on it? If there's no debate, could I have a motion to pass the budget?

Okay, your turn. Mr. Davies.

Mr. Don Davies: Mr. Chair, I move:

> That we adopt the budget as proposed.

The Chair: Is there any debate?

(Motion agreed to)

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

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

Mr. Oliver.

(1240)

Mr. John Oliver: I have circulated a motion. I'm going to make a couple of changes to it as we go forward, but just to quickly explain this, it is a complex bill. It's a fairly substantive change in the norms for how we view marijuana and the use of marijuana in Canada. It's really important. I've been talking to a number of committee members, and there is significant interest in hearing from many witnesses and hearing testimony from different sides of different issues, and if we handle it as we would normally handle our committee business, we could be hearing witnesses for months.

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

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

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

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

Nothing in this bill is restricting that. This is really just about setting up a time for the committee to have a focused four-day period to hear from a number of witnesses around some themes as a way to kick-start our work on this very

important, very significant bill for Canadians. As I said, it doesn't limit further witnesses and it doesn't put time restrictions on the clause-by-clause.

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

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

I am proposing:

> That the committee meet from Monday, September 11 to Thursday, September 14 inclusive for the purpose of consideration of Bill C-45

I'll cut out some of the verbiage here. You have it in front of you. I'm changing “and, that each party send their lists of prioritized”—rather than “proposed”, but it's easier for them if you prioritize the lists—

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

(1245)

I'm proposing that we take those four days and break them into two four-hour blocks per day, with nine witnesses per four-hour block, and that we do two rounds of our normal questioning as well—so it would be nine witnesses and two rounds of the seven-minute, the five-minute and the three-minute questions—and that we organize the blocks into the following category: federal, provincial and territorial responsibilities, which would include retail presentations, revenue questions would be included in there; justice and public safety, so we would hear from the police, RCMP and others, and if there were questions around impact on organized crime, that would be a natural place to include witnesses around that topic; other jurisdictions' experiences, others have gone through this road, so what were the lessons learned. If there were international considerations this would be a point in time to also build in international issues around compliance with other jurisdictions; household cultivation of plants has been a very common question that I've heard from others. It would also give us a chance to hear from landlords and tenants and if there are rental issues on that topic; the age for legal possession and impact on young Canadians; prevention, treatment, low-risk use versus high-risk and health risks; workplace safety. There is a corresponding piece of legislation to this one, which is deal with motor vehicles and heavy equipment, but otherwise what's the impact on workplaces, and appropriate detection, and it would a place to build in how we can detect and understand if somebody's in the workplace under the influence; and then impact on indigenous communities. That would be the eight topic we would deal with.

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

I'm changing number three. It was said, “That witnesses be directed to prepare oral remark...”. I had five minutes in. We can do 10. We normally do 10, with four witnesses, and we usually have about 20 minutes free in a two-hour block. So if we go to nine witnesses in a four-hour block, it's tight. We'll have about a 10-minute window in each four-hour block. The reason I was thinking of five minutes was really for us, just so that we have breaks and the four hours is not that intensive, and that we make sure that we really do ask for written submissions to augment the five-minute. But I think, given our committee practice has been 10 minutes, then we probably should stay at that 10-minute mark.

Then the second change I had in here is “that the witnesses we invited to submit written statements prior to August

18th", which would give time for translation. Is that correct?

Sorry, my misunderstanding. Going back to 10 minutes, we don't to change the timing of the written statements on that one.

Number four really isn't about this week. I'm trying to get this week organized for us, because the House should be rising shortly and I want to make sure we have a good robust week of study of the bill. Four is really about setting deadlines for others. Normally the committee sets a cutoff for when we receive submissions. I think we can deal with that when we come back and have a cutoff set. But I'll leave it in for now and we can have discussions. Four says that the "That the Chair set the deadline for written submissions regarding C-45 to September 1, 2017." Then number five, "That the Minister of Health, the Minister of Justice, and the Minister of Public Safety be invited to appear before the Committee on Thursday, September 14...", which would give us at the end of that week a chance to hear from the ministers involved in this, if they're available, and that they be given 10 minutes for allotted remarks.

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

Thank you.

An hon. member: Instead of September 11?

(1250)

The Chair: We start September 11.

Mr. John Oliver: Sorry, my misunderstanding. Going back to 10 minutes, but we don't to change the timing of the written statements on that one.

Number four really isn't about this week. I'm trying to get this week organized for us, but the House should be rising shortly and I want to make sure we have a good robust week of study of the bill. Four is really about setting deadlines for others. Normally the committee sets a cut-off for when we receive submissions. I think we can deal with that when we come back and have a cut-off set. But I'll leave it in for now and we can have discussions. Four says that the "That the Chair set the deadline for written submissions regarding C-45 to September 1, 2017."

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Thank you.

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

Ms. Harder.

Ms. Rachael Harder: Thank you.

Mr. Oliver, overall this looks good. My only concern is this, one, at the beginning I would like to see a specific time frame set for each day so that it is actually in the motion, the times you're hoping to meet. For example, are you hoping to meet from 8:30 to 12:30, or are you hoping to meet from 6:00 a.m. to 10:00 a.m. What are the time frames that we're working with each day? I'd like that set out here, so I wonder if you would be willing to amend that.

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

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

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

The Chair: Mr. Davies.

Mr. Don Davies: Thank you, Mr. Chair.

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

The Chair: And us.

Mr. Don Davies: And us, of course everybody, and parliamentarians and the people we represent. I don't think it's an exaggeration to say that billions of dollars are at stake, not only on the medicinal front but as we move to Canadians' accessing in a legal way the sale of recreational or adult-use marijuana.

I'm pleased to see that this motion is written in a way that leaves it open-ended to more meetings. I was concerned that if we limit this testimony to four straight days of public input, effectively in the summer before Parliament sits, it can convey to the general public that this committee and this Parliament is looking to restrict public input. I would point out that this part of the legislative process, that this committee phase is the only phase where members of the public and stakeholders have the opportunity to come before Parliament and express their comments on the proposed legislation. I know there was some consultation during the McLellan task force and the government had a website, but that was prior to any legislative framework being designed, and that is what we have before us. So I know there's going to be a lot of people from a lot of different perspectives who will want to have their input into this legislation and frankly I think we will benefit from that input, so I'm very glad. I want to put on the record now that I'm almost certain that out of those four days, as happens with every study we undertake, we learn a lot. Issues arise that we haven't anticipated, although I think that John has done a good job of putting out some of the major areas. I don't think it's quite there yet as I'll say in a moment. It's largely there, but certainly there will be other issues raised from the testimony that I think will raise further questions among us, and so the opportunity to have a further day, or days, of testimony later on in September is important. I'm going to say right now I think it's going to be necessary.

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

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

(1255)

The Chair: This going to be exciting.

Mr. Don Davies: —should really be looking at edibles as a subject. Whether it's covered under this bill, I think we should look at whether it should be covered or not covered.

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

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

I have a couple of final housekeeping matters.

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

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

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

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

Finally, on number i, in terms of federal-provincial responsibilities, I'm not sure that warrants a topic on its own, too. We're a federal committee. We are going to be looking at the federal issues on this, I think.

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

Those are my preliminary comments at this point.

(1300)

The Chair: Thank you very much.

Dr. Carrie.

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

First, I want to say that this is kind of interesting that we are going to get the opportunity to study this bill.

As well, I appreciate the opportunity to discuss this motion, because I know the provinces and territories, there are a lot of questions and the time line of July1 is being seen as an extremely tight time line.

I'll disagree with Don a little about the provinces and territories. I believe they have a lot of questions and I think it's incumbent on this committee to actually allow them to ask those questions and get prompt answers, because the time line to make such a substantial change that's happening here is really going to be tight for them.

There are a couple of recommendations I have that will perhaps move this forward a little more quickly. I agree with Don about the maxim of 72 witnesses. I appreciate John talking about these topics, but I don't think those topics actually have to be in the motion. I think they could be hashed out in a planning meeting. Don brought up some really good points about edibles, things along those lines.

I know it may not be intended to be restrictive, you may not have intended it, but I think it does come across that way and as we discuss it, if there are stakeholders that want to come in and talk about a few different things.

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

They did a good job talking about topics' organizations. They talked about the prohibitions, the obligations' offences, criminal activities, other prohibitions, promotion and what Don said, packaging and labelling, displays, selling and distributing, obligations, a miscellaneous category.

Did they have ticketable offences, because we've heard the debates in the House, even though this is the federal legislation, there are some options for provinces and territories and how that is understood. Licences, permits, general authorizations, ministerial orders, cannabis tracking system, inspections, which is huge. We're finding out with the medical marijuana. Maybe we're not doing that as well as we can, so what are the options for this for the general public?

Disposition of seized things, administrative monetary penalties, transitional provisions in related Controlled Drugs and Substances Act, Criminal Code, coming into force. Coming into force is going to be huge here.

I think the analysts have done a really good job and I think to move the motion forward from my standpoint, I like your amendments to say “prioritized”. I would even take out “a maximum of 72 witnesses” I think, depending if we're doing those two-hour blocks, we might be able to leave it up to the analysts and clerk as they start booking. We might be able to be flexible there. Take out what I see could be interpreted as overly prescriptive, point 1.

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

I'd also ask, as Don said, I was curious to note that it does stop on September 14. I was just wondering is there is something happening on the 15th that we might not be able to. There have been all kind of leaks about what may or may not happen. I'm glad you're not saying that this is it, because I think that as we learn a little more as a committee, I think we're definitely going to need to study it.

In that light as well, No. 4, the chair set the deadline for written submissions. I think we can take out, because at the end of the day, witnesses may hear what other witnesses say and if this goes on a little longer, I wouldn't want to see

them not being able to submit something in a timely manner that we couldn't take into account.

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

(1305)

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

The Chair: Mr. Oliver.

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

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

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

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

I think the workplace safety and Indigenous communities are both important topics. I think the Indigenous communities, I'm sure, will have some views and perspectives on this, but perhaps it's not four hours and maybe we do a two-hour block on workplace safety and a two-hour block on labelling and packaging, and we do a two-hour block on Indigenous communities and a two-hour block on another topic, we could do edibles, or....

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

Mr. John Oliver: Well, Monday, September 11, the goal would be that we would have nine witnesses for the first four-hour block starting whenever the Chair decides—

The Chair: All at the same table at the same time?

Mr. John Oliver: —at 8:30. However you want to structure the four-hour block.

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

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

The Chair: No it doesn't, but four and a half, four and a half.

Mr. John Oliver: Sure, however you want to set the four-hour block up for, Mr. Chair. And then we would break for

an hour, and then have nine witnesses on justice and public safety.

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

Okay, Mr. Davies—oh sorry.

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

I'm happy to split workplace safety with packaging and labelling, happy to split Indigenous communities with—is it edibles that you wanted in, Don?

(1310)

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

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

The Chair: Just a second. Mr. Davies is next after Mr. Oliver.

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

The Chair: Mr. Davies.

Mr. Don Davies: Thanks, Mr. Chair.

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

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

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

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

The Chair: I just want to comment.

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

Mr. Don Davies: I was going to say that I think we're all mindful of the Prime Minister's declared objective to have this legislation in place for July 1, 2018. I, for one, and the New Democrats are generally supportive of this legislation

and generally we want to facilitate that passage, particularly since, as everybody on this committee knows, we've been raising the spectre of Canadians being convicted of possession each and every day that this legislation doesn't get passed, so we want it passed soon.

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

The Chair: —and then the Senate.

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

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

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

(1315)

The Chair: I just got a message from the analyst and she has suggested that they put together a workplan for the steering committee. The problem with doing that is that the steering committee then has to report back to the committee of the whole and then before it's all....

Mr. Colin Carrie: That was my point.

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

Dr. Carrie.

Mr. Colin Carrie: That was one of the things that I was going to actually bring up. At the end of the day, the witness list and everything has to be brought back to the full committee, so if John was saying we'd have to get together in August, then so be it. But again I'll go back to my argument about having one in here. Whether we think it is or not, the way it's written with the four-hour blocks, it's very prescriptive. Again the analysts put forward this very good legislative summary. Depending on the interest, depending on availability, if we did give them a bit of leeway to come up with a work plan for us over that period of time, they've heard about what topics and I think we've heard just around the table here more than eight topics, maybe they can be congealed into even a smaller number of topics or themes as the chair brought up, which I think is a good idea. But to have number one in the motion, it takes away some of the flexibility. That's all I'm thinking here. As this gets out, we may want to spend a bit of extra time here or there. There may be other topics that we weren't thinking of.

I do want to go back to the dates. I thank John for putting them forward. I don't know how this date of Thursday, September 14 came there through the channels of the government, but my worry to have the ministers on the 15th.... The rumours are out there, and we know this place is filled with rumours but if the government does decide to prorogue, one of the days it suggested was the 15th, which means the ministers wouldn't be here. So I would like to have the ministers here sooner than later, particularly the Minister of Justice if we can only get one. I don't know what the cabinet's schedules are going to be like either. This is a priority of the government, and I think if the government wants to get this through, they know the cabinet schedule way in advance and I know it can sometimes be a bit flexible too. It's important to have at least the Minister of Justice here before that date of September 14 because none of us here really know what's going to happen on that 15th.

The Chair: Ms. Harder.

Ms. Rachael Harder: Thank you very much. I certainly echo what my colleague, Colin Carrie, just said. I would also like to come back to the time frame, and it seems now that perhaps, Mr. Oliver, you are amenable to breaking up those four-hour sections into two sections of two hours at the discretion of the chair, which I think is really wise. Just even considering physical space, to get nine witnesses in here is rather a task, so that's worth considering.

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

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

Those would be my amendments that I would suggest.

The Chair: Mr. Kang.

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

I think when we are doing two-hour blocks, instead of having four witnesses we can probably have six witnesses in a two-hour block, so that would give 12 witnesses in four hours and then we could hear 24 witnesses in one day. Bringing in more witnesses is a concern. How many we had here today....

(1320)

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

Mr. Darshan Singh Kang: Those are my comments. Thank you.

The Chair: Mr. Oliver.

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

I want to reiterate that my goal here was to get all of us agreeing that we're going to be back a week early and that we're going to be dedicating ourselves to pretty long days studying Bill C-45 to get us started on the bill. I would be happy if we could move the week to run September 11 to September 15, which actually gives us then two additional four-hour blocks.

We could invite the ministers to come the following week and have them come to a session the week after. We need to hear from the ministers at some point in the process. That would give us two additional four-hour blocks on the Friday, and we could add—

Sorry, Ms. Harder, I didn't mention municipalities because they are a construct of the provinces, so it really falls under provincial/territorial, but we could have a municipality come in that block.

The question I want to come back to is that we are either going to mandate the chair and the clerks to do this and we'll come back to what they've set up and we stay with these general themes plus the ones that have been added, so labelling and packaging, edibles—

Mr. Don Davies: —medicinal.

Mr. John Oliver: —medicinal. The international treaties I had lumped in with other jurisdictions and experiences, but, fine, international treaties, so there are those three additional topics.

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

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

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

I believe—I've been here long enough to know—we have to do this right. If we do this wrong, this side will pay a bigger price than that side, but we have to do it right. I'll do the best I can to do it right, to make sure we hear all the witnesses we need to hear, with no limit on the witnesses. We're not limiting it 6 or 72 or anything else, but if you let this end of the table put something together based on what everybody has said, and pass Mr. Oliver's motion with flexibility, then we'll work it out.

So, all in favour?

Mr. Davies.

Mr. Don Davies: Thank you.

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

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

The Chair: —another 18—

(1325)

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

The reason I proposed that is that, then, frees us from that sort of strict categorical thing. If I can only get one per category, then I have to really work on the categories. It sounds like we're agreeing on the general categories here.

The Chair: I think so.

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

The Chair: Dr. Carrie.

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

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

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

The Chair: Ms. Sidhu.

Ms. Sonia Sidhu: I think it's a very important bill. I agree, if we have breaks, but we have to see how many witnesses. We have the nine witnesses, if they fit in that, and then even though in the half of the lunchtime we can give more space or we can put nine witnesses in there, I think I'm in favour of that.

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

Mr. Oliver.

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

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

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

We have a fairly substantive list now. We've added municipalities, we've added label and packaging, we've added edibles and we've added medical marijuana usage. I just can't think of a way that we.... If you want to have a stand-alone one on international considerations, we could have a stand-alone for that as well, because you can do these in two-hour or four-hour blocks.

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

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

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

(1330)

The Chair: If we move the motion we can pass the budget and it helps the thing move along.

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

Yes, Dr. Carrie.

Mr. Colin Carrie: I actually agree with you and that's why I was saying, let's not rush about the themes. Let's pass the general motion, let's allow you to come back next week, and I'd be happy to sit for another two hours to just do committee business next week and just iron this out and get it figured out because we want to make sure that this is the best bill we can possibly get.

My concern is that if it's too prescriptive and it's in the motion it's binding and we've passed it. If we change our minds or if we get some things we want to add or move around a little bit, we can't do it. If we pass the general motion and then allow us to talk about it next week, just as that top part pretty much with a little bit of that verbiage that you have in there, which I'd like the clerk to read back to us if you don't mind.

Mr. John Oliver: The motion on the floor?

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

Mr. Don Davies: Don't make him.

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

Mr. John Oliver: I've requested the motion to be passed as amended.

The Chair: Okay, and that's with the list that you have here?

Mr. John Oliver: Yes, and I've added“ labelling and packaging, edibles, international consideration, and medical marijuana”—

The Chair: And municipalities...?

Mr. John Oliver: —and “municipalities”, yes.

Ms. Rachael Harder: And “international”...?

Mr. John Oliver: “International considerations”.

We've added six topics. It can be either two-hour or four-hour blocks, depending on how the witnesses come, but more flexibility around which witnesses to which topic, depending on submissions, but generally following committee structure.

The Chair: I have Dr. Eyolfson.

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

The Chair: No, you can't....

Mr. John Oliver: That stops the motion.

Mr. Doug Eyolfson: That stops the motion? No, I'm stopping the debate. I thought that was what we were talking....

I'll withdraw.

The Chair: Okay.

Mr. Davies.

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

Okay, thanks.

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

Mr. Don Davies: “The percentage of seats in the House of Commons”.

The Chair: Dr. Carrie.

Mr. Colin Carrie: I would just add a friendly amendment, too, that after “proposed witness”, add “that the committee meet from Monday, September 11, 2017 to September 15, 2017 in regard to an act respecting cannabis, and to amend the Controlled Drugs and Substances Act from”, and then I'd like to say specifically “8:30 to 10:30; 11:00 to 1:00; 2:00 to 4:00; 4:30 to 6:30, and that each party send their list of prioritized witnesses for the purpose of the study to the Clerk of the Committee by Tuesday, August 1”, so the same all the way down, and put a period after “task” and leave the motion as that.

(1335)

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

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

The Chair: Gary, welcome to the committee.

You're up.

Mr. Gary Anandasangaree (Scarborough—Rouge Park, Lib.): I'm fine.

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

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

The Chair: With the themes listed....

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

The Chair: Mr. Davies.

Mr. Don Davies: I really think we should vote on the motion now as well because, first of all, it's expressed with

guidelines. Colin is right that once it's passed but we can always revisit it. So let's get this passed, have it written up, and then it can be sent to the committee members. If anybody has a serious objection to that motion as passed, he or she can certainly move a motion to amend it next week. We're not going to be acting on this right away, but I think it's important. We may not be here next week.

The Chair: Exactly.

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

The Chair: Dr. Carrie.

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

After “the following guidelines” in your preamble up top there in the motion, just say “but not limited to”. So we have in the motion that it's not limited.

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

Now we have a motion.

All in favour of the motion, as amended.

Did you accept?

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

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

Mr. Colin Carrie: Well to organize this, with all due respect, we've had a lot of talking and I have nothing written in front of me, the motion that we're actually voting on. Don's suggestion that we just vote on it and if we want to change it later, I understand that but we've done a lot of talking back and forth on the motion. What I am concerned with, John, is I just don't want to be too prescriptive.

Unless the clerk can read me back exactly with everything that was put into it what we're actually voting on—this is such an important thing I don't want to rush it—I thought if we put “but not limited to” after your clause at the front end of it, it just gives us that flexibility that I'm looking for. I believe everybody's intention is the same. But we know if there is a discrepancy later on, we'll just go back and say, “Well we did pass this motion.” That gives us a bit more of an open end.

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

Mr. Webber....

Mr. Colin Carrie: But if we're open—

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

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

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

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

The Chair: It's “generally in accordance with”....

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

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

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

The Chair: I have Ms. Sidhu.

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

(1340)

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

Mr. Don Davies: [*inaudible*]

The Chair: We have the motion on the floor.

(Motion agreed to: yeas 6; nays 3)

The Chair: Now we have a budget that I'd like to [*Inaudible*]

All right, everybody has a copy of the budget. Do I have any discussion or a motion on the budget?

Mr. Doug Eyolfson: Can we accept the budget?

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

(Motion agreed to)

The Chair: We don't have a scheduled meeting on Tuesday.