HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 007 • 2nd SESSION • 41st PARLIAMENT

EVIDENCE

Wednesday, November 27, 2013

Chair

Mr. Ben Lobb

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)): Good afternoon, ladies and gentlemen.

This is meeting number seven and we have a number of witnesses who are going to present their information, one through video conference.

We have a little protest outside on Wellington Street today, so the buses were a little slower getting here. One of our members isn't here. We'll start without her and, hopefully, she'll only be a few minutes.

We'll first start with the College of Family Physicians of Canada, Jamie Meuser. He's the guy we see on the screen right now. We'll get him to start, then we'll work with our folks who are here in person.

For the committee's knowledge, we have a little bit of committee business at the end of the meeting, a few minor items, and we'll carry right along.

Go ahead, sir, you have 10 minutes or less. Thank you.

Dr. Jamie Meuser (Associate Executive Director, College of Family Physicians of Canada): Thank you.

Good afternoon, members of the Standing Committee on Health and Mr. Chair.

As associate executive director of the College of Family Physicians of Canada and as a practising family physician, I'm privileged to be with you today and I thank you for the invitation.

The College of Family Physicians of Canada, the CFPC, is the voice of family medicine in Canada and we represent over 30,000 dedicated members. The CFPC advocates on behalf of its members to ensure high quality in the delivery of care. Education is, of course, a key element of our mandate. We establish standards for the training, certification, and ongoing education of family physicians and we're responsible for accrediting post-graduate family medicine training in all of Canada's 17 schools.

My remarks today concern the role that family physicians can play to address prescription drug abuse and misuse and how we can work with patients to find the common ground required to resolve the situations in which there is prescription drug misuse.

Prescription drugs are clearly an important part of managing disease, of curing illness, and of maintaining function. All of us at one point or another are likely to require a prescription of antibiotics, for example for an infection. Some drugs are prescribed for the short term; some for a longer period, such as pain management medications or some antidepressants. Some are required for the duration of a person's life, for example thyroid hormone supplementation in the case of under-functioning or surgical removal of the thyroid gland. Indeed, a 2007 Commonwealth Fund survey found that about half of all Canadian adults take at least one prescription drug on a regular basis.

Because of our place in the health system, family physicians are largely at the centre of prescribing—

● (1535)

The Chair: I'll interrupt for one second, sir. I'm sorry.

[*Translation*]

Ms. Isabelle Morin (Notre-Dame-de-Grâce—Lachine, NDP): Mr. Chair, we are not getting the interpretation in French.

[*English*]

The Chair: Well, that sure provides a little trouble for the committee here.

Mr. Meuser, we'll pause in your presentation for a couple of minutes and see if our technicians can do anything to bring the volume up for the interpreters.

In the meantime, though, we'll move ahead with our people who are here in person. We'll start off with the Canadian Nurses Association. Ms. Roussel or Ms. Bard, you can start your presentation.

Mr. Meuser, bear with us. We'll try and get the situation fixed.

Go ahead, please.

Ms. Rachel Bard (Chief Executive Officer, Canadian Nurses Association): All right.

Good afternoon. My name is Rachel Bard and I am the CEO of the Canadian Nurses Association that represents more than 150,000 registered nurses.

[*Translation*]

I will certainly be able to answer your questions in French.

[*English*]

A nurse's priority, above all else, is his or her patient's well-being. Whether a nurse works in a hospital or in a policy department for government, as a university professor or a researcher, the end result is always better health for Canadians.

Prescription drug abuse is a public health and safety issue across this country. According to a recent national Nanos poll conducted for CNA, nearly a quarter of respondents said they are concerned with a family member or friend's overuse of prescription drugs, second to alcohol abuse, and above illegal drug use.

Overdoses, family breakdowns, blood-borne infections, drug-related violence, and death are all very real consequences of the issue. But prescription drugs are necessary for many Canadians and can have important positive effects in their lives. The problem is not a simple one, nor is the solution.

Thank you very much for inviting CNA here today.

We have three recommendations to make: first, that the federal government support a national strategy to address prescription drug abuse, and we strongly endorse the recommendations of the *First Do No Harm* report from the National Advisory Council on Prescription Drug Misuse; second, that harm reduction be reinstated as a fourth pillar in Canada's national anti-drug strategy; and third, that the federal government provide for the educational and practice needs of health care practitioners, primarily prescribers and dispensers.

Our first recommendation pertains to the comprehensive, multi-faceted national strategy outlined in *First Do No Harm*. CNA was a member of the prescription drug misuse council. We contributed to the report and we are here today to endorse its recommendations. This report is a foundation to our recommendations today. The key aspect is multi-faceted because of the complexity of the issue. There is no simple solution and there are many challenges.

How well is the problem understood? A consistent, pan-Canadian surveillance system, including collection, analysis, and dissemination of information, is needed to better inform policy and practice.

How do we prevent and reduce rates of drug abuse? Due to the complexity of drug abuse, multi-faceted, preventive approaches must be developed and implemented. People who use drugs frequently experience physical and mental health problems and often are socially marginalized. Women, youth, and aboriginal people are especially vulnerable to the harms of drug use, often because they are coping with past trauma, such as physical or sexual abuse. Preventive measures to address these issues involve changes to social policies that leave some Canadians vulnerable, but also implementing policies that can decrease suffering.... Tackling the social determinants of health such as housing, income, education, and community connections creates stability, and that is a foundational step toward prevention.

Do patients fully understand how serious prescription drugs are? We must overcome the notion that prescription drugs are completely safe because that affects every aspect of their use: how they are taken, stored, and disposed of. The public needs to be educated about the risks.

How do we still address pain management, a very serious health problem? Just as we look to social determinants as a root cause of many health problems, we must also look to the health care system to determine what role they play. We cannot simply reduce the prescribing of controlled substances. Pain is the most common reason for seeking health care. But what about wait times, access to different health providers, and access to other types of therapy? The longer patients have to wait for surgery or procedures to correct their pain, the longer they are going to need prescription drugs. If they could have easier access to physiotherapy, occupational therapy, or counselling, could their drug dependence be reduced?

● (1540)

If the health care system improved access to collaborative provider teams, we could enhance the seamless, timely care we provide to Canadians. Consistent relationships and communications between providers and patients, enhanced by technology and electronic health records, allow us to better assess patient histories instead of just dealing with one episode or emergency. Similar to the surveillance system I mentioned earlier, Canada needs to implement prescription monitoring programs to ensure common definitions, reporting, and collection methods are used across all provider groups and throughout system levels.

The National Advisory Council on Prescription Drug Misuse and its many stakeholders put forth this excellent report, which contains a five-pronged approach to prescription drug abuse: education, prevention, treatment, enforcement, and monitoring. I want to underline how foundational this report can be. It contains real, actionable strategies to tackle this issue. What we need now is uptake.

Our second recommendation is that harm reduction be reinstated as a fourth pillar in Canada's national anti-drug strategy, and that the strategy be reviewed by the Auditor General every 10 years to ensure it is meeting the public health objectives. Harm reduction is a pragmatic public health approach that promotes safety while preventing death and disability. Evidence on drug use clearly shows that a harm reduction approach is the most effective method of intervention during periods of active or decreasing drug use.

As the most frequent health providers for people who use drugs, nurses are able to build trusting relationships with them, in part because we recognize that successful treatment includes acknowledging the difficulties of reaching marginalized groups with complex physical and mental health issues. We understand very well how a harm reduction approach supports client-centred delivery of care in a supportive, non-judgmental environment. They have few requirements for admission and are closely linked with much needed health and social services, as well as addictions counselling and treatment services.

In the 1980s, Switzerland was experiencing high rates of HIV and overdose deaths. Thousands of people were without access to services for their drug use issues because of too many requirements, such as abstinence. As a result, traditional health care and social systems were unable to effectively address drug use and its consequences. When services based on harm reduction principles were added to the system, immediate access was opened up to health, social, and other services that were delivered by professionals who understood addictions and were able to build relationships that led to more stability, housing, reconnecting with families, and many other positive changes.

Here in Canada, Vancouver's supervised injection site, Insite, resulted in a 30% increase in the use of detox and long-term addiction treatments. As one element in a comprehensive drug strategy that includes prevention, treatment, and enforcement, harm reduction services are essential to addressing the issue of addictions.

CNA's third recommendation is that the federal government provide for the educational and practice needs of health care practitioners, primarily prescribers and dispensers. Evidence-based information developed in consultation with providers about prescribing practices in relation to prevention and treatment of drug abuse must be available for providers. Nurse practitioners, who are registered nurses with advanced education and experience, are authorized to prescribe certain controlled drugs and substances as defined by the Controlled Drugs and Substances Act.

This development is one example of the positive steps this government is taking to open up access points to care for Canadians. However, it must be met with the development and updating of clinical guidelines that support nursing practice, and the provincial and territorial legislation and regulation frameworks that govern nursing practice. Everyone here today has a role to play in promoting a healthy Canada: health care providers, government employers, and Canadians.

The problem of prescription drug abuse and dependence is a very real one right now.

● (1545)

It is imperative that government and health providers start working together today to advance healthy public policies and to implement strategies at multiple levels of the system, to tackle the issues that contribute to prescription drug abuse and dependence.

[*Translation*]

Thank you for your attention.

[*English*]

The Chair: Thank you very much. You're right on time.

Next up, please, we will have Ms. Ricketts and Mr. Simpson of the Canadian Medical Association for ten minutes.

Dr. Chris Simpson (President-Elect, Canadian Medical Association): Thank you very much.

[*Translation*]

Mr. Chair, members of the committee, good afternoon. Thank you for letting me testify before you as part of your study on the government's role in addressing prescription drug abuse.

[*English*]

This is a serious issue. Let me begin by saying that the CMA shares the concern of governments and other stakeholders about the risks and harms associated with misuse or abuse of prescription medication.

The CMA is particularly concerned about the impact of the abuse and misuse of prescription medication on vulnerable populations, notably seniors, youth, and first nations. It's increasingly recognized that while prescription medication has an important role in health care, the misuse and abuse of controlled psychoactive prescription drugs, notably opioids such as oxycodone, fentanyl, and hydromorphone, are emerging as significant public health and safety issues.

Users of prescription opioids fall into two broad groups: those who use them for therapeutic reasons and those who use them for recreational purposes or because they are addicted. There is considerable overlap between these two groups. For many of those who misuse or abuse, their first exposure to the opioid was therapeutic. The routes for acquiring prescription opioid medication include legitimate prescribing for therapeutic purposes, double doctoring, diversion techniques such as prescription fraud and forgery, thefts, street drug markets, and even Internet purchasing.

[*Translation*]

What are the rates of prescription opioid drug abuse or misuse?

[*English*]

This is a very difficult question. It's generally acknowledged that national data on the abuse and misuse of prescription medications are lacking. However, there is evidence of misuse among vulnerable populations such as youth, first nations, and seniors.

For instance, 14% of respondents to the 2011 Ontario Student Drug Use and Health Survey said they had used opioids in the last year, making this the third-most common drug used after alcohol and marijuana.

A review of the non-insured health benefits program found that 898 opioid prescriptions were dispensed per 1,000 first nations individuals aged 15 or older in Ontario in 2007. The federal government has recently implemented a prescription monitoring program related to the NIHB.

While accurate data on the prevalence of the misuse of prescription medication among seniors are lacking, there is concern that with Canada's aging population, there will be an increasing number of seniors needing treatment for prescription medication-related harms, for example, medication interactions, falls due to drowsiness, or falls due to lack of coordination.

● (1550)

[*Translation*]

This is a snapshot of what is being described as an emerging public health concern.

[*English*]

The CMA is encouraged that federal, provincial, and territorial governments are committed to collaborating to address this issue. In our brief we outline three specific recommendations, which l would like to speak to.

First, in order to truly address the issue, the CMA recommends that federal, provincial, and territorial governments work with stakeholders to implement a pan-Canadian strategy to address the misuse and abuse of prescription medication.

[*Translation*]

To support quality patient care nationwide, such a pan-Canadian strategy must include the following:

[*English*]

an education and awareness-raising component that targets vulnerable populations, such as seniors, first nations, and youth, as well as health care practitioners; and the availability of, and access to, effective pain management and treatment programs.

Addictions treatment is a critical component of quality care. We need to address availability and access to addiction treatment and withdrawal management facilities as well as pain treatment and management across the country, particularly in rural, remote, and native communities. We see a patchwork of resources and approaches across jurisdictions and very importantly among regions within jurisdictions.

Surveillance and research are also needed—notably there needs to be a pan-Canadian interoperable system for real-time monitoring of prescription medication. We will speak more about that shortly.

Of course, we can't forget two other important components of health care: prevention and consumer safety. For prevention this means sustained youth social marketing and safe storage advice. For consumer protection we need slow-release formulations and other forms of tamper-proofing to reduce addiction.

Secondly, the CMA recommends that governments at all levels work with prescribers and the public, industry, and other stakeholders to develop and implement a nationwide strategy to support optimal prescribing and medication use. This strategy should include educational programs for health professionals, point-of-care practice tools and resources, special educational supports such as academic detailing or online communities of expertise to mentor prescribers and provide guidance, and public education to address prevention and safe use of medication.

CMA calls for this strategy in recognition of the challenges physicians face in assessing the condition of patients who request or may need the medication. Physicians assess whether the use is clinically indicated and whether the benefits outweigh the risks. The challenge is that there is no objective test for assessing pain and therefore the prescription of opioids rests to a great extent on mutual trust between the physician and the patient.

There has been progress such as the creation of the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. While there have been efforts to advance the national guideline, more needs to be done to develop and advance point-of-care practice tools.

Thirdly, the CMA recommends that the federal government work with provincial and territorial governments, together with health professional regulatory agencies, to develop a pan-Canadian system of real-time monitoring and surveillance of prescription medication.

Limited access to information and resources is a key gap that physicians struggle with every day. Physicians simply do not have access, in real time, to the information they need at the point of care. A physician in Canada, with the exception of Prince Edward Island, does not have the ability to look up medication history to determine if the patient has received a prescription from another doctor, even in the same community. In some provinces, pharmacists are able to access a database for this information. But this is not true for every jurisdiction. Addressing the lack of information and resources is critical to eliminating a major barrier to effective treatment, and that requires establishment of a pan-Canadian real-time monitoring and surveillance that is interoperable.

It may be true that most provinces have prescription monitoring programs in place. But they differ widely and are not interoperable. Some are administered by regulatory colleges, others by government. They collect different information in different ways.

In addition, most of these programs focus exclusively on education and oversight of physicians but do not address patient needs.

The CMA is advocating a nationwide monitoring and surveillance system with common standards and protocols. It must be linked to electronic health record systems. And it must have the capability for use in enforcement by the regulatory colleges and for data gathering, research, and program evaluations.

As the Canadian Centre on Substance Abuse noted earlier this year in its groundbreaking report, *First Do No Harm*, “Existing activities to monitor the harms associated with prescription drugs in Canada are fragmented.” This must change. CCSA's report concluded that, “The data sources that do exist in Canada, such as coroner reports, poison centre records,…health data, losses and thefts data,…adverse events data, medication incidents and law enforcement records, are not part of any comprehensive national initiative”.

● (1555)

[*Translation*]

Let me wrap up by reiterating CMA's concern with this issue.

[*English*]

Canada's physicians are committed to optimal prescribing and working with governments to address the abuse, misuse, and unsafe use of prescription medication across Canada.

[*Translation*]

Thank you.

[*English*]

The Chair: Thank you very much.

Next up, we have the Institute for Safe Medication Practices Canada, Ms. Ma and Ms. Walsh.

Continue on.

Ms. Jessica Ma (Project Lead, Institute for Safe Medication Practices Canada): Mr. Chair, members of the committee, and staff, the Institute for Safe Medication Practices Canada expresses a great appreciation and honour at being asked to present before you.

ISMP Canada is an independent, not-for-profit organization established to analyze incidents of preventable harm from medications, to identify system improvements, and to advance medication safety. We value opportunities that allow us to share our learning and expertise, and we recognize the benefit of partnership.

Medications have brought forth tremendous benefits to the health of Canadians. Lifespan and life quality have all increased in the past century, due in part to medications that are effective against acute and chronic illness. Over this period, however, there has been increasing awareness that medications can also cause harm. Prescription drug abuse—in particular of opioids, but also stimulants and sedatives—has become a serious issue that threatens some of the most vulnerable citizens.

ISMP Canada recently completed a study, in collaboration with coroners and medical examiners' offices across the country, on preventable medication errors causing death. The results confirm the caution with which opioids should be viewed. Nearly half of all inadvertent deaths in the study were associated with opioids. Even in the context of therapeutic care and without any evidence of purposeful abuse, this class of medications can be harmful.

Our organization also maintains a number of databases whereby practitioners and consumers can report medication errors. Again, the drug class most often reported as causing harm is opioids.

ISMP Canada has traditionally focused our work on medication use in the environment of formalized health care—in hospitals, in clinics, in pharmacies. However, we are becoming more aware that the safe use of medications extends beyond that sphere. We are increasingly conscious that drug safety also implies the prevention of prescription medication abuse and dependence, and the reduction in both intentional and unintentional misuse. To that end, we present to the committee for their consideration three strategies directed toward the reduction of prescription drug misuse, abuse, and dependence.

First, we recognize that prescription drugs are only available from a prescriber and that an improvement in prescribing practices is needed. The findings from our death investigations reveal that patients are often initiated opioids at too high a dose, with inadequate education about side effects and dependence potential, and with insufficient monitoring and review.

According to the U.S. Centers for Disease Control and Prevention, the excessive prescribing of opioid analgesics is fuelling an epidemic of addiction and death. Opioid addiction can and does occur with typical doses that are prescribed for approved indications. Dependence and addiction are relatively common consequences of long-term opioid therapy, occurring in up to one-third of patients in some studies.

Prescribers and patients need a more balanced approach to the treatment of pain, but prescribers do not always have the expertise or resources to institute non-opioid options for pain control. A coordinated effort needs to be undertaken by medical schools, regulatory bodies, professional organizations, and expert panels to enhance prescribing skills and develop expertise in pain management, not only in the general prescribing population but also in specialist pain management centres. This strategy increases awareness of the risk of opioid use and provides tools to prescribers to prevent the harms associated with opioid use.

Second, ISMP Canada uses reporting and surveillance to analyze medication incidents and to develop strategies for safety. Our organization leads the Canadian medication incident reporting and prevention system, a medication error reporting program that shares learning from incidents through safety bulletins and informs standards development.

Canada has shown global leadership and has made adverse drug reaction report information freely available to health care workers and the public. All of these programs benefit heavily from concerned reporting. We cannot overstate the value of this surveillance. Our experience shows that reporters tend to report the severe and unexpected cases of harm from medications, and this helps to detect new signals.

Opioid addiction resulting from the escalated use of prescribed drugs should be viewed as an adverse drug reaction or a preventable event. The acknowledgment of opioid addiction as an adverse event or error will stimulate the increased recognition of the problem, and will enhance reporting.

● (1600)

In turn, interpreting this data will detect contributing factors to harm and inform safe use recommendations. Ultimately, the prudent use of opioids includes ensuring practitioners, together with patients, have enough information to make an educated decision about drug treatment.

Our third strategy relates to the recruitment of patients, families, and caregivers in helping ensure safe medication use. Regulated health-care workers can and do provide a level of protection and care, but it is often the patients themselves and those around the patients who are first able to detect the signs and symptoms of increasing and alarming medication use.

Furthermore, they are frequently in the best position to intervene in the case of a serious adverse event. Findings from both our death investigation study as well as our continuous surveillance analysis has determined that in some cases, signs and symptoms of opioid overdose were noted by family members but tragically these intervention opportunities were not recognized. Patients and families need to be an active part of the opioid use process. They need to be aware of the signs and symptoms of overdose and also the risk factors and indicators of dependence and addiction. But awareness is not enough. All parties in the process—prescribers, pharmacists, home care practitioners, families, and friends—must have a plan, the resources, and the support to intervene when they detect and recognize alarming signs or behaviours.

ISMP Canada has created patient and family-oriented products to educate consumers about the safe use of opioids. A video and patient handout emphasize that opioids can be used safely and effectively but they can also carry risks of serious injury. These products offer information on steps consumers can take to minimize the risk of being harmed by opioids. Importantly, education is provided on the recognition of opioid overdose and actions that can be taken to prevent harm.

In summation to this committee, ISMP Canada recognizes the problems associated with prescription drug misuse, abuse, and dependence and submits that addressing these difficulties will require multiple perspectives, approaches, targets, and strategies. To that end we have proposed three directions: one, improvement in prescribing skills in pain management in opioids; two, defining the opioid dependence or abuse as an adverse event or a medication error, and enhancing associated surveillance and analysis systems; and three, recruiting patients and caregivers as both active monitors and active intervenors in opioid use.

Thank you again.

The Chair: Thank you, Ms. Ma.

I think we're just about ready to try plan B here, with Mr. Meuser.

Sir, can you give it a try to see if we hear can you?

Dr. Jamie Meuser: I hope this is better.

Mr. Chair, should I start from where I was in my presentation or should I start from the beginning?

The Chair: Let's start from the beginning because I'm going to assume my colleagues wouldn't understand because of the interpretation.

So go ahead, sir, you have 10 minutes and we look forward to your presentation.

Dr. Jamie Meuser: Thank you again, Mr. Chair, and members of the Standing Committee on Health.

As associate executive director of the College of Family Physicians of Canada, and as a practising family physician, I'm privileged to be here with you today, and I thank you very much for the invitation.

The College of Family Physicians of Canada, CFPC, is the voice of family medicine in Canada. We represent over 30,000 dedicated members. The CFPC advocates on behalf of its members to ensure high quality in the delivery of care. Education is a key element of our mandate. We establish standards for training, certification, and ongoing education of family physicians, and we're responsible for accrediting post-graduate family medicine training in all of Canada's 17 medical schools.

My remarks today will concern the role family physicians can play to address prescription drug abuse and misuse, and how we can work with patients to find the common ground required to resolve situations in which there is prescription drug misuse.

Prescription drugs are clearly an important part of management of disease, of curing illness, and of maintaining function. All of us at one point or another will likely require prescribed antibiotics, for example, for an infection. Some drugs are prescribed for the short term; some, such as pain management medications, for longer periods; and some are required for the duration of one's life, like thyroid hormone supplementation in the case of an under-functioning or surgically removed thyroid gland. Indeed, a 2007 Commonwealth Fund Survey found about half of all Canadian adults take at least one prescription drug on a regular basis.

Because of our place in the health system, family physicians are largely at the centre of prescribing. Prescriptions for the most common known drugs are usually written by us, but I would be remiss if I didn't note that prescribing decisions—what I mean by that is whether to prescribe, what to prescribe, how much to prescribe—can be the result of many complex factors. These include how a patient reacts or doesn't react to certain medications; the patient's history; other drugs the patient is taking; a patient's preference and income level, including what to do when a lower-income patient does not have a drug benefit plan; and what happens when a patient is prescribed a drug in hospital and then is discharged. All of these are common and predictable determinants of prescribing.

Complexity in family medicine may also be increasing. Aging patients, many with multiple chronic conditions, are a part of almost every family physician's practice. We are also seeing patients discharged sooner from the hospital, and the continuation of care, including the management of prescribed drugs and follow-up tests, become the responsibility of family physicians.

While there are numerous benefits to prescription medications, we're also aware of harms due to prescription drug misuse and abuse. Those harms include severe allergic reactions and a variety of effects related to the known mechanism of the drug's action and effect. For some drugs, the harmful effects can involve addiction; withdrawal; overdose, both intentional and unintentional; as well as suicide.

In a study of opioid drug-related deaths among Ontario drug benefit plan recipients in 2006, 40% of all single opioid deaths were due to a single drug—oxycodone, followed by morphine and heroin. One study also found that, in about two-thirds of opioid-related deaths in Ontario, the victim had been seen by a physician at least a month prior to death. In most cases, the coroner determined that the cause of death was accidental. In other words, we family doctors are implicated in these situations, and often in preventable ways.

In a 2011 study on Ontario primary care physicians' experiences with opioid prescribing, over 95% of family doctors reported prescribing opioids within the previous three months. A majority, 86% of those respondents, reported being confident in their prescribing of opioids, but 42% of respondents indicated that at least one patient had experienced an adverse event related to opioids in the previous year, usually involving oxycodone. And 16.3% of respondents did not know if their patients had experienced any opioid-related adverse events.

I'd like to share with you a story about a patient of mine with long-standing chronic and disabling pain. She was started on morphine with dramatic improvement in function. A few weeks later, I heard from her partner that she had undergone surgery for a bowel obstruction, presumably due to cancer.

● (1605)

When I finally caught up with her in hospital, there was good news and bad news. The good news was that there was no sign of cancer. The bad news was that the morphine I'd prescribed had caused profound constipation, resulting in the need for urgent bowel surgery. I had, in other words, succeeded at compassionate care—succeeded at helping in one way. I had enough knowledge and skill to do that, but not enough to prevent the complications, to prevent the predictable and unnecessary suffering that she underwent as a result of my prescribing. Clearly, I had some work to do—in fact we all had.

The CFPC has taken a position on oxycodone in particular. In November 2012, our board passed the following resolution:

> The CFPC expresses profound concern that any changes that lead to an increase in the Canadian supply of sustained release oxycodone will contribute to further ongoing abuse of this drug and all of the accompanying negative health and social consequences. We call for a comprehensive approach to increase research and education initiatives surrounding appropriate and effective treatment strategies for patients who suffer from chronic pain.

The CFPC takes its role of social accountability seriously. We know that family physicians must take steps to assist in the reduction of prescription drug abuse and misuse. We recommend that this issue be addressed using the framework from the report, *First Do No Harm: Responding to Canada's Prescription Drug Crisis*. The CFPC was a member of the National Advisory Council on Prescription Drug Misuse and contributed to this report.

I'm going to spend a moment to focus on education for family physicians, adequate supports, and collaboration. Currently, gaps can easily be found in continuing education programs offered to primary care physicians regarding prescription drugs. By developing and delivering a curriculum for health care practitioners, we can educate prescribers and dispensers about the harms associated with the use of different medications. As family physicians, this is especially important because it helps us to open up a dialogue with one another in our local practice communities and with our patients by better informing them of the potential harms of prescription drugs. It also allows patients to participate in the shared decision-making process, which ensures that they're taking an active part in patient-centred care.

As family physicians, it's important for us to have access to unbiased education and support when assessing and managing cases of drug misuse, as well as to assess access referral pathways when a patient's problem becomes severe. Support models, such as the shared care and collaborative care models, involve local networks of pain, addictions, mental health, primary care, and other sectors. The collaborative nature of these models helps recognize the role and usefulness of team-based approaches. It also helps promote information sharing, dialogue, and teamwork exchange between health care practitioners and other service providers to address the stigma and fears linked to the use of these medications.

Having access to a network of experts—either physically or through the use of communication technologies such as webinars and telemedicine—can provide supervision, mentorship, and peer consultation to primary care providers throughout Canada. This is especially beneficial to embracing access to expertise in under-serviced areas.

The CFPC is taking a leadership role through our model of care provision, called the patient's medical home. This vision for a family practice advocates for a team-based, patient-centred approach. By creating multidisciplinary teams, such as family health teams and primary care networks, we're able to provide a full range of treatment options related to pain, mental illness, and addiction.

Thank you once again for this opportunity to present a family medicine perspective on this issue, and I commend the Standing Committee on Health for undertaking this important study.

● (1610)

The Chair: Thank you very much for your very frank comments there. I'm sure the committee really appreciates those.

We're going to enter into our first round of questions, which are seven minutes in length.

First up to ask the questions is Ms. Davies. Go ahead.

Ms. Libby Davies (Vancouver East, NDP): Thank you very much, Chairperson.

Dr. Meuser, thank you for sharing and using yourself as an example of what can happen with a prescription. It's not an easy thing to do.

It's very interesting to hear all the witnesses today because I think we're really beginning to get a sense of how complex this issue is and how the system—if there is a system—is not working very well. That's becoming more and more evident.

Madam Bard, thank you so much for raising the issue of harm reduction and the fact that it does need to be reinstated. It was part of Canada's drug strategy and it was dropped in 2007. I think the most salient point that I picked up from that, and you used Insite as an example but there are many other examples, is that harm reduction is really part of the continuum of treatment. It's not something that's separate. It's a very misunderstood term, unfortunately, that has become very politicized. It would be great if we could strip that away and look at it as part of the continuum of health care.

A couple of questions arise for me—well, many questions. Dr. Simpson, I would ask for your thoughts about this monitoring real-time interoperable system that you spoke about. It sounds like a great thing that should be done. How realistic is that? Are there any models in other countries that we could look at? I know that in B.C. we have a system, but it's mostly based at the pharmacy level. You were speaking about it being linked back to electronic health records, and the physician would be the primary point. I think that's what you were getting at. I'm interested in hearing a little bit more about that.

For the other witnesses, we've heard a lot about OxyContin. That's obviously the most dramatic example of prescription abuse or even misuse in terms of the way it's being prescribed. I'm curious to know if there are other, not necessarily addictive, situations with other drugs where basically prescribing is taking place when it's not needed, where people are taking things for years and years and they actually don't need it anymore, and it just becomes this routine. What kinds of checks and balances are there in the system to prevent that? I think it would be easy for us to be caught up in the drama of oxycodone and it's important, but I'm also concerned about the system overall. We seem to be so over-prescribed, which I guess falls into the misuse category, I'm not sure. I wonder if some of you would respond to that as well.

● (1615)

Dr. Chris Simpson: I'll take the first stab at some of those.

One of the truths that we can all agree on is that the point of engagement between the prescriber and the patient is the time when things can go wrong, or they can go right, or some combination in between. I think what we're saying is that, for the physician or nurse or other prescriber who is faced with having to make a decision on a very complex issue, they're doing that with incomplete information. Better point-of-care tools would enhance the appropriateness, allow for better assessment of addiction potential, and would bring in collateral history like other prescriptions. I think that is getting to your question of whether there is some way to have information about whether or not these medications have been prescribed elsewhere.

Anecdotally we have stories all the time of the pharmacist calling the physician back and saying, “Do you realize this is the fourth prescription for this?” If you bring that back to the point where the decision to issue the prescription is actually made, that's what's going to give us the biggest bang for the buck. It's putting those tools in the hands of the prescribers.

Linking it to electronic medical records seems like a logical way to do it. We've had great difficulty, of course, coming up with an integrated system of medical records in Canada. Many well-intentioned people have died on that political hill. Nevertheless, that is still the desired end point, to have that kind of real-time information.

You also commented on the ongoing nature of this. It's not just the single point in time, obviously, when a decision is made to prescribe. There have to be ongoing mechanisms for reassessment of the need, reassessment of the dose, reassessment of all kinds of other subtle aspects of how the condition for which the treatment has been prescribed is going. It is the caregiver's responsibility to ensure that the relationship with the patient continues and that reassessment happens on a continuous basis. This is not just a one-time decision.

● (1620)

The Chair: We'll let Mr. Meuser go ahead.

Dr. Jamie Meuser: It's right at the centre of our minds when we're thinking about prescription drug misuse. That's why our board went out of their way to make that motion in 2012 that I cited. In fact, what we see with this drug is true, as you said Ms. Davies, about a number of drugs we prescribe. Our goal with prescribing is to bring our prescribing decisions closer to the centre of what science tells us should be done. The truth is, that's often astonishingly difficult. The easy example to point to is the use of antibiotics for viral infections. This is so common as to be almost a standard of care, and we believe it's common because it appears to be something that patients and families in our communities expect.

I'll tell one other story about a challenge around applying science to prescribing. That relates to my first foray into continuing education, which was around improving antibiotic prescribing. We know from science that, for instance, acute ear infections in kids over two years of age can be treated equally well with antibiotics and non-antibiotics. In other words, using watchful waiting for treating ear infections is an effective treatment. We undertook an educational program to try to make this scientific reality part of a standard of care. We thought the targets for that education would be physicians, of course, but parents and also, probably, pharmacists.

What surprised us when we dug deeper was that there were other influences on the prescribing decision that we had no idea about, the most important of which were day care workers and mothers-in-law! These are the people who influence parents around whether they would insist on a prescription from their physician, the day care workers saying things like, “Don't bring that kid back to daycare until they're on a prescription” or mothers-in-law saying things like, “What do you mean you didn't get a prescription from the doctor for that ear infection? Of course you need a prescription for that.” The lesson for us was that we have to thoroughly understand and thoroughly pay attention to all the influences attendant on all the medications we prescribe. It's not a simple decision.

The Chair: Thank you. We're way over time, so Ms. Bard, we'll get your comments at a later time. I can assure the committee, there are no mothers-in-law in the crowd today.

Ms. Adams.

Ms. Eve Adams (Mississauga—Brampton South, CPC): Thanks very much. Allow me to thank all of you for coming here and joining us today, and to welcome all of you.

I'd like to congratulate, obviously, the new president-elect of the CMA. I'm looking forward to working with you.

I'd like to offer a very warm welcome to Dr. Meuser from Mississauga. In addition to being the parliamentary secretary to health, I'm also the member of Parliament for Mississauga-Brampton South. We have member of Parliament Lizon here, who also hails from Mississauga. Indeed, we are pleased to have you here.

You've provided a reasonable overview of some of the surveillance tools that are available to monitor prescription drug abuse. Could you, perhaps, elaborate on that and offer us some of your expertise on how we can augment that, as well as how well we're doing at exchanging and sharing information and, again, how we can improve upon that?

Ms. Rachel Bard: If I may add my observation in relation to that, there's clearly a need to create bridges to cover the transition between acute care and the community. Because patients do flow from one system to the other, we need to have a better mechanism.

Electronic exchange of information is one area, the second one is e-pharmacy. If we can have a repository so that electronically the pharmacies who are filling out prescribed drugs can see if there are interactions, where the flow is, and how many doors a person is going through, you can start connecting with the service provider. These are good examples.

We also need to build the capacity to better understand drug interactions. We heard examples of impacts based on the combination of medications. We need to have information communicated electronically about drug interaction and side effects, adverse effects. Then decisions and monitoring can be based on actual facts.

● (1625)

Ms. Eve Adams: Could you also—perhaps directed to the CMA or to the College of Family Physicians—provide an overview of the clinical practice guidelines that are available right now to physicians to assist them to not over-prescribe prescription drugs?

Dr. Jamie Meuser: I'll start, if you like. There's certainly no shortage of clinical practice guidelines in any of the areas of drug prescribing. In fact, our problem in many ways is not that there's not enough information, but that there's in fact too much information. The difficulty for family physicians often is deciding which guideline to pay attention to and which part of which guideline to pay attention to.

Certainly, guideline-based prescribing is an important part of the care we give, but one of the difficulties is that guidelines are often very dense technical documents that are full of recommendations, many of which are not prioritized and all of which might pertain to a given patient, and many of which may not. We have the task, in applying guideline-based care, of deciding what guidelines to apply to what patients and to recognize that we have many patients who have seven or eight guidelines that apply to them in any given clinical situation, some of which will conflict with each other.

Guideline-based prescribing is only part of the story. We need to have a way of making our way through the forest of guidelines towards patient care decision-making that encompasses what's best for that particular patient sitting in front of you and for their preferences and values.

Ms. Eve Adams: What would you suggest as the improvement?

Dr. Jamie Meuser: At our level, we're working at building consensus. We're working on connecting members electronically to help members themselves help each other make difficult clinical decisions about patient care when there isn't a guideline that applies or when too many guidelines apply.

So certainly, the linkage of colleagues across our college is part of it, and certainly as well, collaboration with specialist groups, many of which are involved in the production and dissemination of these guidelines.

Ms. Eve Adams: Thank you.

Dr. Chris Simpson: Maybe to provide another little context around that, back in Kingston last night I was speaking about this with an emergency room physician I highly respect. He said that 20 years ago we used opioids to treat patients for palliative care or for cancer pain, and we did a really crummy job treating everybody with non-cancer chronic pain.

Over that 20 years, opioids and other drugs have emerged as legitimate therapeutic agents. The guidelines that have been referred to have been an attempt to define, I think, what that best practice would be, and I think they've largely done that. What we're talking about now is the unintended consequence of having successfully treated a large number of people with chronic pain; now we have the fallout, which hasn't been as well managed.

The guidelines I think are good, and the challenge is going to be in the knowledge translation, in getting them into practice, off the paper and into practice. One of the things we've done, working with a group based at McMaster University, is work to develop these knowledge-for-practice tools that can be used at the bedside. We've cosponsored an online education module based on those guidelines that is being developed by a group at Memorial.

So there's certainly a role, I think, for professional groups to participate in this kind of knowledge translation. There potentially could be a role for governments as well to assist in the dissemination of good information—information that we all agree is reasonable—and making sure that it translates into the way things really roll out on the ground.

● (1630)

Ms. Eve Adams: I think Ms. Bard also wanted to respond.

Ms. Rachel Bard: If I may just add to that, I think I would say as well that you can translate the guidelines into tools, but tools that are not limited just to providers. There can be tools for family members, for them to have a better understanding of some of the implications, and fact sheets for patients and fact sheets for dispensers, so that you have easy-to-access, retrievable, and concise information that can be used on a day-to-day basis.

The Chair: Quickly, Ms. Ricketts.

Dr. Maura Ricketts (Director, Policy and Research, Canadian Medical Association): I was just wondering how many of you have ever read the instructions for your TV changer, one of those hand-held devices?

Clinical practice guidelines are worse than that. The point is that converting these things into tools that can be used at point of care requires that an effort be taken to do so. You need people who understand what's happening at the clinical setting, and they reorganize the information so it makes sense from the doctor or prescriber/patient interaction point. It takes a concerted effort to do those things and that's why resources are required for it.

I'll also point out that pharmaceutical companies use academic detailing because it works. Academic detailing is an excellent way to work with any prescriber to help them use the best practices in their clinical practice setting. But these things require resources, leadership, and an intent to make the entire system work better.

The Chair: Okay, thank you very much. That concludes that seven-minute round.

Ms. Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): I want to thank everyone who came here today.

I think, with an exception, all of you are prescribers to some extent, so I wanted to focus on the fact that prescribers are one piece of the problem, issue, solution, or whatever you want to call it.

I think what we heard from you, and what I think some of us know, is that the first step is to provide the appropriate drug for pain, regardless of what the pain is, whether it is palliative care, cancer, post-operative pain, pain because of a broken bone, or something like that. I think that's the first thing. I know there are guidelines for doing this, but how do you track appropriate prescribing?

The second one of course is surveillance, which is the physicians surveying the prescriber. Who surveys the prescriber? How does that surveillance occur without making the person being surveyed feel like they are threatened? How do you do that surveillance? And are we talking about tools then so that you can look at those prescribing practices?

This is the first piece of it. I know that when addictionologists first started addictionology, when it first became a specialty, addictionologists were saying that before you give patient A a particular drug you should do a history and a family history to see whether that patient has a propensity or if there is some sort of history within their family of people who are addicted to alcohol or inappropriately use all kinds of substances, including smoking. That might trigger you to decide on what particular medication to give to that person that has the least ability to cause addiction. Most of these drugs are addictive drugs so I know that that's a difficult problem.

The second one is, and I know I've repeated this before and I don't know how many of you know, in British Columbia about 20 to 25 years ago they started something called a triplicate prescription. The triplicate prescription meant that every time you prescribed an opioid, a barbiturate, or a narcotic of any kind, you had to use that prescription pad. That prescription pad had three pieces, one kept by the doctor, one sent to the college of pharmacists, and one sent to the college of physicians and surgeons in the province. That way they were able to keep track of what doctor was prescribing what drug, how often, and whether it was an appropriate prescribing practice or not. It was also able to pick up double doctoring in that province, so doctors and pharmacists were sent a list every week of people to look out for, including their aliases, who came and asked for drugs.

If we had that across the country and one was able to therefore track—not only within the province but outside of the province for a patient who from comes from another province—would that be an effective way of monitoring appropriate prescribing practices, tracking, and surveillance? I think that might be an important piece. I'm sure Dr. Meuser knows that there's going to be a patient who walks into your office and says, look at me, man, I've had this accident, I've got this God-awful pain that's been going on for 12 years, and I can't move my back. My doctor in Saskatchewan has been given this to me for a long time. Unless you call the doctor in Saskatchewan, and sometimes you can't get a hold of the doctor at the time, or you refuse the drug to the patient, there is no way of knowing whether this person is bona fide or not. I wanted to ask those questions, because I want to get to the nitty-gritty of the tools that are necessary to appropriately prescribe in the first place, and to track and survey.

I'm open to whoever wants to start.

Go ahead, Chris.

● (1635)

Dr. Chris Simpson: These are very interesting questions about appropriateness, because, of course, appropriateness is very difficult to define.

You're well aware, I'm sure, of the Choosing Wisely initiative, whereby medical practitioners are trying to say upfront that we recognize that appropriateness is something that can be enhanced. It's one of those things you kind of know when you see them, but it's kind of difficult to define. Ultimately, I suppose the way forward is to have some sort of reduction in the practice variation we see, have some sort of unanimity around what constitutes good practice, and then have the outcomes be the measure.

So it really speaks to how this part of the problem has to be wrapped up in the bigger envelope of managing pain in Canada, because at the end of the day we want people to be in as little pain as possible, and we want to have as few people addicted as possible, and we want to have as much of the inappropriate prescribing disappear as possible. Those are the outcomes we're trying to reach, and if we reach those, we will have increased appropriateness by definition. The most powerful tools are those that measure these important outcomes and give us ways to access best practices and to assure ourselves and others that we are following best practices.

The idea of monitoring prescriptions, I think, has met with modest success in the past, but really I suppose it's a red flag. If you find that Dr. X prescribes 10 times as much as Dr. Y, does that mean that Dr. X is prescribing inappropriately, or does it mean that he has a different practice profile? It may be sort of a signal that we need to go in and look a little bit deeper. It may be the first pass, but it may not be the sole tool required.

Hon. Hedy Fry: But it is a tool.

Dr. Chris Simpson: It is a tool, and hopefully it would be electronic and not three sheets of paper anymore.

Hon. Hedy Fry: Dr. Meuser, did you have anything to add?

Sorry, Chair, I should go through you.

Dr. Jamie Meuser: It's hard to argue against improved information, and I think we would all agree that the more information we have when it comes to making that prescribing decision, the better it is, both about the drugs we're prescribing and certainly about the individual patient and the risks they bring when they are on the receiving end of that prescribing decision.

Having said that, I think we in family medicine are used to making decisions—and important ones—based on incomplete information. We do it all the time. Unfortunately, uncertainty and ambiguity are our constant companions in the work we do every day. So I think the truth is that most of the difficulties we see in prescribing are based on decisions that are made with the best possible intentions. What we attempt to build in are certainly supports for the information we have when we make that decision as well as other kinds of supports to clinical decision-making.

In Ontario, for instance, there is an opioid prescribing mentorship network that has been created by the Ontario College of Family Physicians that links family physicians to others—pain and addiction specialists as well as other family physician colleagues—so that when they run up against a particularly difficult decision around this prescribing conundrum, they have a group of colleagues they can refer to on a relatively instant basis to help them make that decision.

Hon. Hedy Fry: Thank you.

Dr. Bard, I wanted to ask you if you saw this as being some kind of cross-country thing?

● (1640)

The Chair: Ms. Fry, we're at eight minutes here now.

Hon. Hedy Fry: I'm sorry.

The Chair: I'm sorry.

Ms. Bard.

Ms. Rachel Bard: Just for the record, I think the report *First Do No Harm* has a good section and shows the cross-responsibility at the provider level, the government level, and the local level. I think I would advise the committee to really look at some of those surveys, because they are needed.

The Chair: Perfect. I thank you, and I'm sure our analysts are making copious notes here and have likely read it three or four times.

Mr. Hawn, go ahead for seven minutes, please.

Hon. Laurie Hawn (Edmonton Centre, CPC): Thank you very much, Mr. Chair.

Thank you all for being here.

Dr. Simpson, first, you said that 898 out of 1,000 first nations youth fifteen and over have had therapeutic prescriptions for opioids. Is that 898 of 1,000 individuals, or is that 45 individuals getting 20 prescriptions?

Dr. Chris Simpson: That's 898 prescriptions per 1,000 individuals. That doesn't mean 898 individuals.

Hon. Laurie Hawn: Okay, thank you. I'm far less shocked now.

Now, just on that, or on tracking other prescriptions, and along with what Dr. Fry was saying, it seems to me that there's a problem with training and standards, not that anybody's training or standards are necessarily inefficient, it's just there's inconsistency and difficulty in tracking that. On the explosion of medical marijuana prescriptions, and that is an explosion from a disproportionately smaller number of doctors, and we've talked about it a little, is there anything you can add about effective ways to track that? I know we've talked about some in B.C., and that seems to be effective.

Is the CMA going to push for a standardization across the country for some of these things, which I think, as Dr. Fry said, would be a good idea?

Dr. Chris Simpson: Certainly, I think there's a role for professional societies to play in some of the knowledge transfer. I think there's also a potential role for levels of government, and the federal government, in particular, to play a leadership role, to work together with the provincial and territorial governments to help develop a prescription monitoring and data collection system.

I think this is the information that gives us all the power we need to make better decisions and then for monitoring the progress made on the problems. How are we going to know if we're getting any better if we can't measure it in some way?

Hon. Laurie Hawn: Is that sort of approach accepted across the medical profession, writ large? Would doctors buy into that? The tracking should be used to educate. Is there a fear that some of the tracking might be used to punish in some way?

Dr. Chris Simpson: I don't have that sense. I think what I'm hearing from my colleagues, and I think most other associations would likely take the same tack, is that we value information. Information gives us more ability to make the appropriate decisions for the patients.

Dr. Meuser said we're used to working in information vacuums. We use our judgment all the time, and I don't see more information as derogating the value of that judgment. It would inform our judgment and make us better physicians.

Hon. Laurie Hawn: Okay. It seems like there's a training deficiency somewhere and maybe that's just because of the advances in medicines available and being pushed by pharmaceuticals, and so on. But is there something missing?

Maybe Dr. Meuser could comment on this from a family doctor perspective. Is there anything missing from medical school training in respect of this, because it seems like a lot of the training is on the job?

Dr. Jamie Meuser: A lot of the training is on the job and part of it is that every patient is different and every situation is different, so, in fact, it's certainly hard to train for every situation you're going to encounter in a brief period of medical school.

Having said that, we certainly have come to believe that, for instance, having a better understanding of pain, what contributes to pain, and how it can be analyzed and treated is a more important aspect of medical training than we had realized, perhaps, in the past.

The problem is you can say that about 20 things that we now know that we didn't know five years ago. The medical school curriculum is only so long. What we're doing about that is being very active on the level of continuing professional development, continuing education for physicians, and increasingly...for teams in family medicine, to help us stay on top of the ways medicine and patient problem-solving are changing.

● (1645)

Hon. Laurie Hawn: Thank you.

Dr. Simpson, are there any territoriality challenges with the various colleges of physicians and surgeons across the country? Or are they pretty united and uniform in supporting the initiatives in this area?

Dr. Chris Simpson: I think there's quite a bit of unanimity around this issue. We're all motivated by doing the maximum good for the patient and minimizing the harm. I think on the principles you've heard here today and the intent, there would be widespread unanimity in the profession and in all health care professions, I would venture to say.

Hon. Laurie Hawn: Go ahead, Dr. Ricketts.

Dr. Maura Ricketts: Thank you very much for the opportunity.

When you asked the question about whether physicians are concerned that they're just being policed about these matters, I want to take it in a different direction. What we're keen on is patient-oriented care, and you can design your surveillance system to prove whether or not you're interested in patient-oriented care or policing.

Patient-oriented care means your surveillance system provides the information to the provider at the point of care. Policing systems gather up all the information for use later, and then reach out and punish. It's too late; the harm's done. That's something I want to emphasize.

Hon. Laurie Hawn: No, I agree. I'm not suggesting a policing system. I'm suggesting an education system with the focus on patient care; it was just whether there was any fear that it might be used in that way.

Dr. Maura Ricketts: Yes, exactly.

And I'm sorry, I didn't mean to imply that you'd made that suggestion.

Hon. Laurie Hawn: No, no.

Dr. Maura Ricketts: With the continuing professional development point, it is a part of all licensed health care providers. Once again, the issue of the evolving information base and the need for clinically oriented guidance that you can use in the health care setting means that an individual person actually cannot keep up with everything.

To support the practitioners, you need to have all of these systems that the others in the room have already described. I just wanted to support those statements.

Hon. Laurie Hawn: I understand.

That's it, Mr. Chair.

The Chair: We're now heading into our five-minute rounds.

I'd just like to mention to the Institute for Safe Medication Practices that if at any time you want to get in on a point, don't be shy. We want to make sure you're heard during the meeting as well. That's just an open invitation from me.

Mr. Morin, five minutes, sir.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Thank you very much, Mr. Chair.

Ms. Bard, thank you for your testimony. I particularly appreciated the fact that you reminded us of the importance of the fourth pillar in Canada's National Anti-Drug Strategy: harm reduction.

As my colleague Libby Davies pointed out, before 2007, this was part of the Canadian anti-drug policy. But, as priorities change when a new government arrives, in 2007, one year after the Conservative government took power, the fourth pillar disappeared. I already know your position on harm reduction and its importance in Canada, and I would like to know the position of the other witnesses.

[*English*]

Should harm reduction be reinstated in the Canadian anti-drug strategy?

[*Translation*]

Ms. Rachel Bard: Let me make a comment while my colleagues prepare their answers.

We feel that it is of critical importance to provide prevention and to reduce the risks. It is the basis of all prevention. People have to be educated and provided with a safe environment so that we can identify and provide the care they need.

[*English*]

Dr. Jamie Meuser: I'll just say that the College of Family Physicians of Canada endorses the report from the National Advisory Council on Prescription Drug Misuse, which validated harm reduction as one of the important strategies in dealing with drug misuse.

● (1650)

Dr. Maura Ricketts: To add to my colleagues' words on this, I think there is an essential misunderstanding of what's meant by the words “harm reduction”. I think most of medicine is harm reduction. A person with diabetes who receives treatment for diabetes is in the throes of harm reduction interventions. When you educate people about diabetes, about heart disease, this is harm reduction being done.

I almost wish we had a new phrase for it, because it's just so core to the practice of medicine, it just doesn't quite....

It isn't easy to understand how it became such a political item.

Mr. Dany Morin: But I'm not clear on the answer from the CMA. When we look at the strategy itself, the wording, it talks about three pillars, so the fourth pillar, named harm reduction, which was in it before, was reduced.

What is your position on this? Does the CMA believe that harm reduction should be put again in the strategy—yes or no?

Dr. Chris Simpson: We believe it should be in the strategy.

Mr. Dany Morin: Thank you very much.

How about the Institute for Safe Medication Practices?

Ms. Donna Walsh (Educator, Institute for Safe Medication Practices Canada): I'd say that ISMP Canada doesn't have an official position on this, but I would put forward the notion that we do value patient safety and would very much value the input from clients and families in their treatment and their care.

So if it were something that included them and included families, it might be something for consideration.

[*Translation*]

Mr. Dany Morin: Ms. Bard, harm reduction was removed in 2007. In the opinion of the Canadian Nurses Association, what effects, positive or negative, has that had? What have been the consequences for Canadians, both on patients who use medications and the "junkies", the people who, unfortunately, are seriously addicted to the medications?

Ms. Rachel Bard: We need supervised injection sites. We need to reduce the risks and the complications that arise from poor practices such as the use of dirty needles. That is one way to reduce risks. If we do not have sites of that kind, we are making a mistake. It is a way of helping people with their addiction problems. Sites like that can be a way into the ability to develop a relationship with them, to guide them as they search for rehabilitation services, and so on. For us, they are part of the solution. They must not be looked on negatively, but proactively.

[*English*]

The Chair: Thank you, Ms. Bard.

Mr. Dreeshen, you have five minutes.

Mr. Earl Dreeshen (Red Deer, CPC): Thank you very much, Mr. Chair.

Thank you to our witnesses today.

I want to talk about some of the best practices and the safety initiatives we have. According to reports from IMS and some of the figures we've been given here today, 453 million prescriptions were filled in 2008. We're talking about 14 prescriptions per Canadian. You mentioned 898 opiate prescriptions per 1,000 for first nations and even though that wasn't 898 people, that is a lot of opiates being given to any population.

Then you also talked about medication among seniors and the concerns and issues that are associated with that. I'll mention one anecdote. I have an aunt who celebrated her 100th birthday two years ago and had never taken a prescription drug. She'll be celebrating her 102nd very soon.

I take a look at that and I try to look at all the different abuse. When I think about that.... You also mentioned something about the caregiver intervention. The first thing that came to my mind was when someone has come home, who is looking after the individual there? I also recognize there's another way of looking at it, which is of course the physicians and the nurses and so on.

If it goes beyond the mother-in-law's thoughts of what is taking place, when you have a prescription drug being used by a member, when he comes back from hospital and is being taken care of, how do you determine where the adverse effects of that drug come in? Half the time I hear people say they tried this drug and it gave this side effect, so they had to get a different drug. They would check to see what those side effects were going to be. I'm wondering how we are able to keep track of that and if there's a way in which, as we try to do the advocacy, as Ms. Ma was saying, people could find out what the adverse reactions are going to be, or if they start to see them, whom they should be talking to.

● (1655)

Ms. Rachel Bard: If I can answer from a nurse practitioner's perspective, evidently when you are in front of a patient you look at it in a comprehensive way. You look at the total care and the total aspect of the individual so you start to try to map out some of the different interactions or reactions that the person has experienced so you start to do some clinical analysis. Then you can try to adjust and also provide some education to the patient in terms of what to expect and what to flag. It is part of the total care of an individual. It's critical.

Mr. Earl Dreeshen: Ms. Ma.

Ms. Jessica Ma: It's a great question. I think that one of the pieces we try to work with, with our consumer advocacy, is to have a better understanding of medications and the link to illness. I don't think that piece is quite clear in the public eye. We could do a better job as health care practitioners in making sure that people understand the medications they're on and why they're on them, and that they can be part of the monitoring in assessment of these medications.

Yesterday I was at a research meeting on home care. There's a growing push to community care and having these patients manage their medications on their own. Their caregivers don't quite understand the implications of all the meds and how they put them together. As we increase our education to our consumers there will be better understanding of their medications and more information for their family physicians when they visit.

Mr. Earl Dreeshen: Dr. Simpson.

Dr. Chris Simpson: I think there are pockets of excellence in the country where some of these approaches are employed, and where there's a multidisciplinary approach that truly has the patient at the centre and that has all the follow-up and supports in place. It's telling that it takes that kind of a resource-intensive, complicated enterprise to do it well. It reveals what a complex recalcitrant problem pain management is. The difficulties in Canada of course are in the rural and remote areas, and in certain demographic groups that have particular challenges by virtue of their socio-economic status and other demographic differences.

Many family doctors in remote areas—and Jamie will no doubt expand on this—will tell you they don't have any multidisciplinary team there. They're it, and opioids are all they have. There's no physiotherapist or occupational therapist there. So there's this inequity of resources available to patients that we really need to get at if we want a national approach. If we want to introduce some sort of uniform assessment and treatment of some of these patients, we can't do that by simply focusing on what we are going to do differently about prescribing, but on what we are going to do differently about treating these patients in pain.

Mr. Earl Dreeshen: Thank you.

The Chair: Thank you, Mr. Dreeshen.

Ms. Morin.

[*Translation*]

Ms. Isabelle Morin: Ms. Bard, I would like to start by saying how happy I was to hear you talk about the social determinants of health in your speech. As you mentioned, this goes beyond prevention; we have to have marketing campaigns aimed at young people. Other witnesses have said the same thing. Medications must be stored better. We must go to First Nations communities and educate them about the negative effects of prescription drug abuse. Housing is also a very important social determinant. I am happy that a group is sensitive to it. Yours is the first to have said so here.

Let me move to another matter. A 2009 report published by IMS Health revealed that Canada's pharmacists filled 453 million prescriptions in 2008. That is an average of 14 prescriptions per Canadian. That figure certainly struck me. Michel Perron, the Chief Executive Officer of the Canadian Centre on Substance Abuse, appeared before the committee last week. He told us that a good deal of the education that physicians receive after finishing their training is funded by the pharmaceutical industry. Unfortunately, I do not think that we are going to have anyone from the pharmaceutical sector with us for this study, but I have a question for Mr. Meuser. What is your position on that situation?

Let me tell you about an example from my personal experience. Previously, I was a French teacher. When publishing companies came to see us in order to sell their books, those were the books that the school bought for the following year. It has an influence, for sure.

Mr. Perron even told us that physicians receive less training than veterinarians and that the training they get comes from the pharmaceutical industry. Do you see a conflict of interest there? I would like to hear your opinion, and Mr. Simpson's.

● (1700)

[*English*]

Dr. Jamie Meuser: In our system of accrediting continuing education, we have built into that system very strong and strict safeguards against bias and lack of balance entry into the programs where you get credits. We're very stringent on ensuring that the evidence that's put in front of our members around the education they get on prescribing, among many other things, is based on science and not on marketing. That's a clear requirement that we have.

Dr. Simpson mentioned the success that pharmaceutical companies have had with detailing. I completely agree with him that we could take a lesson from that. One of the interventions that we know succeeds—and pharmaceutical companies have known this forever—is establishing a relationship with a prescriber in the context of education. The only reason we can't do that is resources. Resources need to be applied by us around presenting scientific rather than marketing to prescribers that would allow for a broad range of important clinical decision-making questions to be addressed with members of the health care team at all levels.

Dr. Chris Simpson: Certainly government investment in impartial continuing education and knowledge transfer, and some of the programs we've suggested in our brief is a way to disseminate that kind of information in a non-biased way.

I think it's fair to say in general that the health professional community has moved away from, more than at any time in the past, or has resisted influence by marketing individuals. Again, often in many communities and for many health professionals, the information that's disseminated by pharmaceutical companies is still too prevalent, so we'd be very supportive of what you said around that.

I wanted to add as well, I appreciate your comments about the social determinants of health. At the CMA this has been our top priority, particularly during our past president's presidency, Anna Reid, so we're certainly appreciative of those comments.

The Chair: Thank you very much.

Ms. Morin, your time is up.

Next up is Mr. Lizon for five minutes.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Thank you very much, Mr. Chair. Thank you, everybody, for coming to the committee today. Thank you, Dr. Meuser.

First, doctor, I remember when I was growing up I never used to get a prescription for an ear infection. My grandmother and my mother used to look after that for all of us, if I remember correctly. I don't know where your comment about a mother-in-law comes from. I thought it was the opposite.

I wanted to start with what you mentioned about unintended consequences. It's not anything new. If you read the literature, there are examples of people getting hooked on heroin that initially was used to treat pain and they liked the experience. I don't know how we should assess why we haven't been able to learn anything from that, or whether it's something that was simply overlooked. Maybe you could comment.

● (1705)

Dr. Jamie Meuser: I'll start and I'm sure others will contribute to this. I think what you've put your finger on is really at the core of the problem.

We wouldn't prescribe these drugs if they weren't powerful, so these are powerful agents for good, but they are also powerful agents of potential harm. The problem is we can't look into the future and see with any degree of certainty whether any given prescription is going to cause more good than harm.

We can certainly, based on risk factors, based on genetics, based on past experience with this particular patient, try to predict that, but in fact the power of these medications for both good and harm is at the core of the issue that we're talking about today.

What we're emphasizing these days as a starting point for treatment, and I'm sure a few of our witnesses here today will agree with me, is non-drug treatments around all the conditions that people are up against. People working on diet and lifestyle questions, working on physiotherapy or rehabilitation measures that can help deal with pain, as the speaker before said, addressing some of the most important non-medical determinants of whether someone gets sick or gets better quickly is equally as important as writing the right prescription.

Mr. Wladyslaw Lizon: Thank you.

Ms. Rachel Bard: I think the only thing I would add as well is that the interdisciplinary team is essential. If you want to try to reduce the use of drugs, you need to reduce the wait time and really make services accessible in a reasonable timeframe, and connect the right professionals around the person. Approach it that way, so that you use the least invasive and the least intrusive approach first.

Mr. Wladyslaw Lizon: Mr. Chair, how much time do I have left?

The Chair: A minute and a half.

Mr. Wladyslaw Lizon: Yes, go ahead.

Dr. Chris Simpson: Certainly, I'd support what has been said. I think at the core of this is the decision we make every day as health care practitioners, how do we balance the benefit against the risks? We and patients always accept some degree of risk in order to derive the benefit. The challenge going forward is finding ways to enhance that ratio and make that ratio as good as we can.

We can't lose sight of the good that these drugs have done. Any solution that we come up with can't sacrifice the good that has been done. It can't erase or reverse that good that has been done. At the same time we must acknowledge the harm that has come as well.

At the individual practitioner level, it's going to be putting tools in their hands that allow them to make decisions with their patients, confidently, that this is a risk worth taking, the benefits are what we're expecting, and we have an ongoing plan for follow-up to make sure that what we are expecting to happen, will happen.

Mr. Wladyslaw Lizon: I have just one quick question. I don't know if there's a quick answer to it. I don't think Canada is the only country where the problem exists. Therefore, is there a country in the world that has made some attempts to deal with and address the issue? Could we adopt their solutions here?

The Chair: You have about 10 seconds to answer the question, and then I'm going to have to move on.

Ms. Rachel Bard: I mentioned that Switzerland did bring a program that was very effective. I think that is one country to look at.

The Chair: Okay. Thank you very much.

This is the last round of questions for the afternoon.

Ms. Davies, you have five minutes, please.

Ms. Libby Davies: Thank you very much.

I'm going to follow up on the question that Ms. Morin raised, and that is the role of pharmaceuticals. First of all, I believe we are going to hear from Rx&D, because I happened to run into one of their representatives today and I think they are coming to our last meeting, so we will hear from them directly.

Who monitors what is being sent to physicians and whether or not the information is appropriate? Dr. Simpson, you talked about how in remote areas physicians are pretty well on their own; they don't have a multidisciplinary team or other colleagues who they can go to. I'm just curious to know. We're talking about a multi-billion dollar industry here, so obviously there's the issue of pushing new prescriptions. I've seen those books in doctors' offices. They're huge, and you sometimes see physicians flipping through them, but who monitors that? Is there any monitoring? Do we need to pay attention to that to make sure that it's not just a marketing thing, but that it really is centred on proper guidance about what an appropriate prescription is?

● (1710)

Dr. Chris Simpson: I wouldn't want to speak for them, certainly, but over the years there's been a significant change in the way that the pharmaceutical industry interacts with health care practitioners. They're governed, I know, by a code of conduct that's determined internally. The typical interaction in 2013 is usually, “Have you seen this paper that was published?”, “Have you seen these guidelines?” The influence is much more subtle, but of course it is still there. That's why they do it. That's why detailing works so well.

Ms. Libby Davies: Do you personally see them? Do representatives still come to visit physicians and say “How about this?” How does that actually work?

Dr. Chris Simpson: Less and less, and in academic environments where there are learners, it's increasingly strict. Sometimes there's complete prohibition in some of our academic centres; however, in more remote areas they do remain one of the primary sources of information, but I defer to Jamie's expertise.

Ms. Libby Davies: Dr. Meuser, and then maybe Madame Bard.

Dr. Jamie Meuser: We also build in incentives here. We can't control the information that is sent or given to family physicians either by mail, by detailers who drop in, and so on. However, what our members require is a certain number of accredited hours of education in order to maintain their membership in the college and their licence to practise. In fact, it's those accredited hours of education when we do have control over the content and where we can, in fact, quite strictly police the difference between true education and marketing.

Ms. Libby Davies: Does Madame Bard have time to respond?

Ms. Rachel Bard: I would just add that actually your licensing body, your regulatory body, also has a role to monitor and look at the practice of prescribing. But it is a clinical decision to use the information that is provided by drug companies. You need to look at it and then use your clinical judgment in terms of what is applicable or not. But a regulatory body would be—

Ms. Libby Davies: Who is actually monitoring it, though, and making sure it's not being abused by the marketing of pharmaceuticals? Is anybody kind of watching that? Is there any system in place? How do we know if it's working or not?

Ms. Rachel Bard: It is a good question. The only thing I would add—

The Chair: Go ahead, Dr. Meuser.

Dr. Jamie Meuser: The truth is that, like everybody else in society, our members—the family physicians—are exposed to marketing messages all the time, and they can differentiate between marketing and education. So, in fact, I think that they recognize a hierarchy of information they get from all sources. When information comes to them that is clearly marketing, whether it's a brochure or a visit from an employee of a drug company, they can take the information and process it in that way. When it comes to them as education, they have to be able to believe that it comes from a different source, and it's presented with a different thrust. I think the capacity is there to do that.

The Chair: Okay, Ms. Bard, did you have anything you wanted to add?

Ms. Rachel Bard: I think it is a good question. We are planning to provide a document and a copy of our presentation. We will look at that, to see if there is some information we can provide additionally.

● (1715)

The Chair: Thank you very much. That is going to wrap up this portion of our meeting.

I say to any of the people who were here today, and to Dr. Meuser, that if there's anything that came to your mind during the discussion here today that you would like to forward to the clerk of the committee, feel free to do so. I appreciate your frank answers that added to the discussion today.

We're going to suspend for a couple minutes, and then we will get into committee business in camera.

Thank you.

[*Proceedings continue in camera*]