HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 014 • 2nd SESSION • 41st PARLIAMENT

EVIDENCE

Thursday, February 13, 2014

Chair

Mr. Ben Lobb

Standing Committee on Health

Thursday, February 13, 2014

● (0845)

[*English*]

The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)): Welcome to everybody. We have a big slate this morning. We have four presenters so we'll get right to it.

This is the final meeting, as far as hearing content, for our prescription drug abuse study. It has come and gone very fast.

If we have time at the end of the meeting, I'd like to, if it's the committee's will, take the meeting in camera for a couple of minutes to discuss future business. I know it's not on the agenda but if we have time I would like to take a few minutes to do that.

Because of the size of the group we have here today and because three of the four are on video conference, I would ask that our members of Parliament here ask questions specific to the person they're asking the question to and make sure they get a chance to answer the question. Then you can get on to the next one, just so it's clear to them.

What we'll do, and as we've done in previous meetings where we have people on video conference, we'll have them go first. That will ensure we have the technology working at the start of the meeting so that if something happens during the meeting, at least we'll have your testimony down.

We'll start off in British Columbia. Our guests are up very early this morning and likely have had a couple of coffees to get charged up.

At the Orchard Recovery Center, we have Lorinda Strang and Dr. Maire Durnin-Goodman.

Can you hear me okay in British Columbia?

Dr. Maire Durnin (Physician, Orchard Recovery Center): Yes we can. Can you hear us?

The Chair: Loud and clear....

You have 10 minutes to present. We'll turn the time over to you now. Thank you very much.

Ms. Lorinda Strang (Executive Director, Orchard Recovery Center): Thank you, Mr. Chair and members of the committee.

My name is Lorinda Strang and I'm the executive director of the Orchard Recovery Center on Bowen Island, which is a private drug and alcohol treatment centre in B.C. I'm also the co-founder of Faces and Voices of Recovery Canada, and I helped initiate the first Recovery Day in Canada. I'm also a person in long-term recovery. For me, that means I haven't used drugs or alcohol for over 24 years. I'm passionate about speaking openly about my long-term recovery, as it helped me change my life for the better. I've made it my life's work to make it possible for others to do the same.

My work at the Orchard puts me face to face with those who have suffered the extreme consequences of prescription drug abuse and misuse, which include loss of health, careers, and families, and the loss of dignity and self-respect. I'm also witness to the absolute joy and beauty of those who find recovery.

Today I'd like to speak on two points: monitoring surveillance, and then reducing the stigma of addiction and celebrating recovery.

I believe quite strongly that in all proceedings, people who are in early recovery should be listened to as well as people in long-term recovery. I make the distinction, because people in early recovery who we see at the treatment centre are usually in their first 42 to 90 days going into their first year of recovery, and they're often fresh in the pain and the throes of detox.

I believe that data should be collected from treatment centres and shared nationally. Attached is a sample letter of drug trends that we collected just from 2010 to 2013 and the first month of this year from the Orchard Recovery Center. I believe that a national data centre for reporting should be implemented. Treatment centres could volunteer to sign in and report to an online registry. I think that would be quite easy for us to do and to give data and information.

I know that there are some new CareCards out there now with photo ID, and I believe this should be mandatory. Currently, patients, I believe, should show ID when seeing the doctor and again when they pick up their prescriptions from the pharmacy. I believe that there should be more communication between the doctors and the pharmacies to reduce fraud. I know that they have started doing some computer-printed prescriptions. What I hear from the addicts we treat is that there's a lot of fraud going on with prescription pads. This is right from the mouths of some of the younger clients. If the doctors could use a special ink or a different colour of pen, it would make it more difficult for them.

How to protect yourself from medication fraud? I think that a monthly or weekly sheet could be sent out to all pharmacies, physicians, dentists, and veterinarians. I believe that the treatment centres could be giving valuable tips on what the current trends are for how a lot of the younger patients are actually committing fraud to get their prescriptions.

I've attached a few sample letters written by some of our alumni. One is “A Drug Fiend's Manifesto”, which he wrote to all doctors as an anonymous letter. That client is now eight years clean from OxyContin. Letters from patients during and after detox from OxyContin are attached, and quotes and suggestions from those in early recovery. I've also attached a current example of drug trend reporting to show what kind of data you could be collecting from treatment centres.

In closing, I would just like to say I also believe strongly that reducing the stigma of addiction and celebrating recovery is of vital importance. Sharing our stories helps others reach out for help. Advocacy and awareness campaigns support three of the action streams in the “First Do No Harm” report. They help support prevention, education, and treatment.

Faces and Voices of Recovery Canada envisions a world in which recovery from addiction is both commonplace and a celebrated reality, a world where no person will ever feel shame when reaching out for help. This includes family members, who often feel shame and are afraid to reach out for help for their families.

Initiatives such as Recovery Day, and Faces and Voices of Recovery Canada keep our country engaged in a national conversation. In only two years, Recovery Day events have spread to 12 cities in Canada, with thousands of Canadians coming out to celebrate and show our country that recovery works.

● (0850)

Faces and Voices of Recovery Canada is dedicated to mobilizing the millions of Canadians in recovery from addiction along with their friends, families, and allies. We believe that our stories have power. When speaking on the national prescription drug crisis in our country, we need people who are in long-term recovery from prescription drug abuse to come out and share their stories. That helps other people. It shows families that there's hope and that there is a way out of this.

I believe a national framework for action for the prescription drug crisis has been completed by the CCSA, led by Michel Perron, in the First Do No Harm report, and I ask the Government of Canada to do whatever is necessary for the five action streams to be acted upon.

Thank you.

Dr. Maire Durnin: How much time is left?

The Chair: You have four minutes.

Dr. Maire Durnin: I'm going to be very brief. I'm Dr. Durnin and I work in addiction throughout this city, including with Lorinda. I'm going to ask the committee, based on previous comments that you've heard, for four actions.

Number one, you have to have a public campaign to address the stigmatization. I see it with doctors, nurses, counsellors, other addiction patients. I see great ignorance throughout this province and this country about what addiction actually means, what methadone treatment means, and I emphasize proper methadone treatment or Suboxone treatment, where indicated, for opiate-addicted patients.

Our patients feel incredible shame, and heaping public perception and comments from those who ought to know better, or who don't know, increases the burden incredibly on these patients in getting better. Hazelden, one of the premier treatment centres in the U.S., and recently Bellwood, a major treatment centre in Ontario, have within the last two years acknowledged the need for chronic opiate-agonist therapy in selected patients, rather than complete detox. These decisions are based on clinical evidence, and nobody should be stigmatized for choosing that option with their doctor. We would never endure this stigma for any other chronic disease.

Secondly, I'm asking that you consider return-to-work programs that specifically take into account the needs of patients with addiction disorder. I will remind you that these patients are often young, able patients and they would otherwise be contributing to your tax bases instead of sucking resources from it. Their needs are very different. They have lost their skills. They may not be able to return to their former work, if they had it, and they're now faced with working menial tasks with long hours. Part of their requirements include return to recovery activities as part of what they do. In my experience, they often risk losing their jobs because they have to leave work to come to my office, to go to AA meetings, to do urine monitoring, etc. They are fragile. They need your help and they need to return to work successfully to give them back their dignity.

As part of this, I am asking that you consider funding for all opiate therapy when it is indicated, in the proper setting, because our patients are usually financially challenged in their early stages, and they need that help to get back on their feet. This also helps me as a physician to ensure that it is properly prescribed and properly administered. You're well aware that there's a lot of abuse of the system out there and part of what is happening is due to the fact that my patients cannot afford their medications, especially in early recovery.

Thirdly, I'm asking you to consider benzodiazepines. They are dangerous medications. This is a class of sedative-hypnotics that is pervasive in our society. It not only includes Valium and Xanax, etc., but also the so-called “Z” drugs, zopiclone, which are commonly used as sleeping aids. They are used chronically for sleep and anxiety. When they're used, at best, it is usually for the short term, other than in certain mental health diagnoses. They cause memory impairment, falls, sedation, and particularly in combination with opiates or alcohol, overdose and death. They're extremely habit-forming, and my patients hate getting off them and they resist me all the way. I'm asking for increased regulation for this class of medication, such as duplicate prescription or triplicate prescription, as currently exists for opiates. Doctors need to be aware and accountable for what they are prescribing for these patients in this respect, because these medications are widely, widely abused.

The same arguments apply to Tylenol 3, and tramadol, etc., which are not currently regulated by triplicate prescribing, and for Tylenol 1, which my patients buy over the counter. It contains codeine. They take too much of it and they kill their livers.

Lastly, I'm going to speak about chronic pain control issues. It's a real issue, and the fact that it's a difficult issue to deal with doesn't mean that family doctors shouldn't be dealing with it. However, as you've heard from other speakers, they only have opiates in their armamentarium. There are tools out there; you've heard about them already. I'm asking not only that access to these tools be improved, but I'm also asking that family doctors be better reimbursed for taking the time to do this. You must remember that family doctors get paid per patient. If family doctors take the time to deal with these patients, who are some of the most taxing and exhausting we deal with, then they are financially penalized for taking that step.

I'm asking you to also improve the access to alternative measures, which include counselling, physiotherapy, cognitive behavioural therapy, etc., as per Dr. Kahan's suggestions—and you'll be talking to him later. I don't believe that family doctors should be absolved from caring for these patients, but these patients definitely need increased care.

Finally in closing, I'm going to draw your attention to the placement criteria of the American Society of Addiction Medicine, which are some of the tools you may find useful in guiding your decisions. It talks about where an addict is at this point in time, and I note the comment from Dr. Peter Selby, from your earlier speakers, of the right treatment for the right patient at this particular point in time, because our patients' needs change over the continuum.

● (0855)

I'll stop there. I'm sorry. I've been very fast.

The Chair: Thank you very much for that excellent presentation.

Next up we have Dr. Meldon Kahan.

You have 10 minutes, sir. Go ahead.

Dr. Meldon Kahan (Medical Director, Women's College Hospital, As an Individual): Thank you for giving me the opportunity to present to this committee. I commend you on the important work you're doing.

I am currently the medical director of the substance use service at Women's College Hospital and an associate professor in the Department of Family and Community Medicine at U of T.

Before considering ways to deal with the opioid crisis, we first have to understand how we got here.

Back in the 1990s, the pharmaceutical company Purdue launched a massive advertising campaign for OxyContin. The campaign consisted of a few simple messages for doctors: controlled-release opioids such as OxyContin are less addicting than immediate-release opioids; addiction is extremely rare in patients with chronic pain; opioids are remarkably safe and effective; and there is no ceiling dose, that is, doctors can prescribe OxyContin in doses as high as necessary to relieve the pain.

This was the most successful pharmaceutical marketing campaign in history and it completely transformed physicians' prescribing habits, yet these messages are simply not true. Opioids are of modest benefit, their long-term effectiveness is uncertain, and high doses increase the risk of addiction, overdose, and falls.

As a result, we are experiencing a unique iatrogenic—or physician-caused—public health crisis. In Ontario, there are 500 deaths per year from overdose. No other prescribed medication comes close to the suffering caused by opioids. Most of the people whose lives have been destroyed by opioids were not out seeking out opioids to get high. In fact, they were first exposed to opioids through a legitimate prescription for chronic pain.

Simply put, the root cause of the opioid epidemic is that physicians are prescribing opioids to too many patients at too high a dose. The good news is that since the crisis is caused by physicians, it can be solved by physicians, with the help of policy-makers and the public.

There are three areas that need attention: prevention of opioid addiction, prevention of overdose, and treatment. Provincial drug plans can play an important role in prevention by putting limits on reimbursement of high doses of opioids. The federal non-insured health benefits program has such limits, as does the Workplace Safety and Insurance Board in Ontario. The Ontario drug benefits plan is considering limits as well.

Medical regulators, that is, the provincial Colleges of Physicians and Surgeons, could reduce the harm of prescription opioids by establishing explicit prescribing standards. Physicians listen to their colleges. The basis for these standards is already laid out in the Canadian guideline on safe and effective prescribing of opioids for chronic non-cancer pain. This approach has been successful in other jurisdictions, such as Washington state.

Another critical need is to overhaul how product monographs are produced. A product monograph provides detailed information for physicians on how to prescribe the drug. The monograph is written by the company that makes the drug and is reviewed by Health Canada. Physicians view the product monograph as the definitive source of information on the drug. The OxyContin product monograph did not set those limits, and it did not properly warn physicians about the risks of high opioid doses. Current monographs for opioids and other drugs also have major inaccuracies.

This problem can be solved if Health Canada withholds approval until the monograph has been reviewed by independent objective experts. Internal staff at Health Canada simply do not have the expertise to do a meaningful review of the monographs for the hundreds of medications currently on the market. An objective expert review might have helped prevent or at least lessen the OxyContin tragedy.

Education is also of crucial importance. First of all, medical schools, residency programs, and organizations that accredit continuing education for practising physicians should ensure that medical education is free of company influence. Otherwise, we will see more crises like this in the future.

The three most important educational messages are these. First, do not prescribe opioids to patients at high risk for addiction unless absolutely necessary. Second, very few patients need high doses, and the chances of overdose, addiction, falls, and accidents increase substantially with the dose prescribed. Third, patients with both pain and addiction experience marked improvements in pain, mood, and function when their opioid dose is tapered or discontinued.

● (0900)

Turning to prevention of overdose, I believe the first task is a public awareness campaign. All patients must understand that giving or selling opioids to others is dangerous. The patient's opioid dose is safe because it is being slowly increased by the doctor, but if another person takes the same dose they could die of an overdose.

Also, patients need to keep their opioid medication in a safe and secure location, especially if they have adolescent children at home.

Provincial ministries of health can significantly reduce overdose deaths if they reimburse take-home prescriptions for naloxone. Naloxone programs in the U.S. have been shown to reduce opioid overdose deaths. Naloxone is inexpensive and very safe. Right now naloxone is distributed only through a few small needle exchange programs, so very few addicted patients have access to naloxone.

Take-home naloxone prescriptions should be accompanied by education. Simple messages such as “never use alone” can save lives.

Abstinence-based addiction treatment programs should also distribute naloxone to opioid-addicted patients on discharge because they have a very high relapse rate.

I'd like to turn now to treatment priorities. There are two main medical treatments for opioid dependence in Canada: methadone and buprenorphine. Methadone is very effective, but physicians must have special training before prescribing it, and many smaller communities do not have a physician with a methadone licence.

Buprenorphine or Suboxone is almost as effective as methadone, but is far safer. Buprenorphine can be safely prescribed by primary care physicians even if they are not trained in methadone prescribing.

Buprenorphine has transformed some remote communities that have been devastated by opioid addiction. For example, Sioux Lookout in northern Ontario has about 50,000 inhabitants scattered among some 50 first nation communities. Up to 50% of the adults in some of these communities are addicted to opioids, causing widespread crime, violence, family breakup, suicide, and overdose.

Methadone is not feasible in these communities, but over 400 patients are currently in buprenorphine treatment programs. This is truly a local community initiative. The treatment programs are organized and run by band leaders and by the physicians, nurses, and counsellors who live and work there. The health of these communities has improved dramatically.

The Sioux Lookout experience has been made possible because Ontario covers buprenorphine on its drug formulary and NIHB has followed suit. But outside of Ontario, NIHB and most provincial drug plans do not cover buprenorphine unless it is prescribed by a methadone physician. But since most communities do not have a methadone physician, this means that tens of thousands of patients have no access to either medication. In my view this denies the human rights of opioid-addicted patients to receive basic health care.

Both methadone and buprenorphine are on the WHO list of essential medications. The Canadian public would not tolerate this for any other medical condition.

I strongly urge provincial drug plans, NIHB, and provincial medical regulators to remove barriers to access to these life-saving medications.

Another priority is to create a more evidence-based integrated treatment system. Many treatment programs are abstinence-based. Patients often prefer abstinence-based treatment programs but they are not as effective as opioid substitution treatment with methadone or buprenorphine.

An integrated approach is needed and if the patient chooses abstinence-based treatment and then relapses, the program should immediately introduce opioid substitution therapy. The patient should not have to search for opioid substitution treatment elsewhere and should not have to endure long waiting lists and complicated assessment procedures.

I truly believe this crisis is solvable if patients, practitioners, and policy-makers work together to improve physicians' prescribing practices, introduce simple strategies to prevent overdose, and create a treatment system that is effective and accessible to all.

Thank you.

● (0905)

The Chair: Thank you, Dr. Kahan.

Next we have Dr. Navindra Persaud.

Doctor, go ahead, and you have 10 minutes or less.

Dr. Navindra Persaud (Staff Physician, St.Michael's Hospital, As an Individual): Thank you, and good morning.

I'm a family doctor and researcher at St. Michael's Hospital in Toronto and a lecturer in the Department of Family and Community Medicine at the University of Toronto.

Before I begin my remarks, I would like to register my support for the suggestions made by my colleagues in British Columbia and by Dr. Kahan.

Pharmaceutical companies produce medications that can improve and save lives. Sometimes the inappropriate marketing of potentially beneficial medications results in great harm to patients.

One pharmaceutical company, Purdue Pharma, has admitted to illegally mismarketing opioid pain medications in the United States. I am going to discuss one important similarity between the illegal and harmful marketing described in the agreed statement of facts in Purdue Pharma's American guilty plea and the marketing that's in place here in Canada.

The similarity is the claim that new opioid formulations have a lower abuse potential than older opioid medications. Health care providers want to help patients who are in pain. Opioids can be effective at alleviating pain that lasts a few hours or days, and they are commonly used in hospitalized patients, for example in patients who have undergone surgery.

In the 1980s physicians were reluctant to prescribe opioids to patients with mild or persistent pain because of the abuse potential. The tendency for opioids to be abused or harmfully used has been known since the first synthetic opioid, diacetylmorphine, was marketed in the late 19th century. Diacetylmorphine is now known as heroin, and in some countries it is still prescribed by physicians, mostly for pain near the end of life.

In the 2007 agreed statement of facts, Purdue Pharma admitted it attempted to counter the bad reputation opioids such as heroin had by misleading physicians about the abuse potential of new opioid formulations such as OxyContin. Market research done by Purdue indicated that the abuse potential of opioids was a reason physicians hesitated to write prescriptions for these drugs. Product information for OxyContin, Purdue's eventual bestseller, included the false claim that the formulation of the drug was believed to reduce the abuse liability.

Purdue sales representatives were instructed to visit physicians and tell them that these opioids—I'm again quoting from the agreed statement of facts signed by Purdue—had less addiction potential, had less abuse potential, and even could be used to "weed out" people who are addicted to opioids.

The sales representatives were also instructed to boast that OxyContin was more difficult to use intravenously than other medications, even though Purdue's own studies indicated that most of the drug could be extracted simply by crushing tablets and stirring them in water prior to injection.

These claims that newer opioid formulations had a lower abuse potential were known to be false at the time they were made. In fact, Purdue had requested permission from the United States Food and Drug Administration to make these claims, and those requests were flatly denied. There was never any evidence that these opioid formulations carried a lower abuse potential.

Unfortunately, similar false claims were made here in Canada. A reference book that was paid for and distributed by Purdue in Canada entitled *Managing Pain* contained the claim that new opioid formulations had a lower abuse potential. The book was distributed to clinicians by sales representatives, and it was even distributed to medical students. Purdue paid some physicians to deliver educational sessions throughout the country.

Inaccuracies and false claims were disseminated in print advertisements in medical journals, such as the *Canadian Medical Association Journal*, which is mailed to almost every physician in Canada. The ads were approved by the Pharmaceutical Advertising Advisory Board of Canada.

On September 30, 2010, I attended a lecture in Bowmanville, Ontario, given by an assessor for the College of Physicians and Surgeons of Ontario. The title of the talk was "Opioids and the College" and methods for record-keeping around opioid prescribing that would pass the college's standards were discussed. The talk was sponsored by Purdue Pharma. Sales representatives from Purdue Pharma were present and actively distributing promotional materials for Purdue products.

I have here a certificate I received that day that would have qualified me to receive continuing medical education credits from the College of Family Physicians of Canada for attending this pharmaceutical industry-funded talk.

Physicians as a group played an active role in unquestioningly accepting, acting on, and disseminating the misinformation that Purdue Pharma generated, even though less biased sources of information were readily available.

The present close ties between the pharmaceutical industry and the medical profession are inappropriate and completely unnecessary. Other health care industries such as the medical testing industry are profitable and provide good jobs for Canadians without engaging in aggressive or illegal marketing. In fact, these industries have little or no direct contact with physicians. Physicians generally obtain information about appropriate medical testing from sources more reliable than the companies that profit from them. The same should be true for medications.

● (0910)

At the time that all of this was happening in Canada, to my knowledge, no regulatory action was taken. Even in 2007 when Purdue Pharma pled guilty to fraudulently mismarketing practices in the United States, nothing happened in Canada. There was no investigation in Canada, no sanction in Canada, nothing. Prescription rates actually accelerated.

After the false and misleading marketing of opioids had taken place in Canada and in response to a complaint by a colleague and me, Health Canada acknowledged that the lower abuse potential claim was inappropriately made in Canada. Regarding the lower abuse potential claim in the 2002 edition of the Purdue's *Managing Pain* book, a letter from Health Canada dated May 25, 2012 stated:

> Of course, should this issue had been brought to our attention back in 2002, Health Canada would have contacted Purdue Pharma to implement corrective measures.

Health Canada does not proactively monitor industry claims about their products so produced distortion of the addictive potential of newer opioid formulations went unrecognized and no action was taken. The exact number of Canadians who have died of an opioid overdose since 2002 is unknown. Health Canada does not track this. But estimates range from 5,000 to more than 10,000 deaths. Many more Canadians have been devastated by the non-fatal harms of opioids.

Is there a connection between the false “lower abuse potential” claim and the well-documented harms to Canadians? It is impossible to become addicted to a drug without exposure to it. There are countless people in Canada who never would have been exposed to opioids if physicians had not been misled about their abuse potential. Physicians would have continued to exercise the caution about opioid abuse that was revealed by Purdue's market research and subsequently targeted by Purdue's admittedly illegal marketing campaign.

In the United States the connection between the mismarketing and harm was established to the tune of more than $600 million that Purdue paid after pleading guilty. We would know if Purdue Pharma illegally marketed long-acting opioids in Canada if there was an investigation. There has apparently been no such investigation, criminal or otherwise, here in Canada, even though there is documentary evidence that false claims were made.

The government's role in curbing prescription drug abuse should include the effective regulation of pharmaceutical marketing in Canada. The comprehensive and protracted failure of Canadian regulators in the case of opioid marketing has had lethal consequences for Canadians. The difference between the actions of American regulators and the inaction of Canadian regulators should prompt drastic changes here.

In the future the Canadian government should: one, proactively regulate the marketing of medications that may be harmfully misused; two, closely monitor for harms associated with these medications; and most importantly, three, act decisively when inappropriate marketing or medication harms are detected.

I raise these concerns and suggestions today in the hope that this committee will resolve to make real changes that will protect Canadians from misinformation about medications, medications that can either harm or heal.

● (0915)

The Chair: Okay, thank you very much, Dr. Persaud.

That concludes our video-conference presentations and now we move on to our real live witness here this morning. We have Dr. Craig Landau and he is the president and CEO of Purdue Pharma.

Dr. Craig Landau (President and Chief Executive Officer, Purdue Pharma Canada): Thank you.

Bonjour. I am Craig Landau, and I want to thank the committee for the opportunity to appear.

I am the president of Purdue Pharma here in Canada. I've held this position for four months. I am new to the country and I'm also new to the company. I'm also a physician. I'm an anesthesiologist and a pain doctor, to be exact. I've treated hundreds, if not thousands, of patients in multiple settings—the civilian setting, including the academic environment; and also the United States military, in the army, where I was part of a combat support hospital providing services in support of the previous and/or ongoing conflicts in both Afghanistan and Iraq.

As an aside, long before coming to Canada, I had the privilege of serving alongside and training with a number of my counterparts from Canada in military medicine.

I've treated patients in pain, and I've dealt with the consequences, both good and bad, so I have an understanding of the benefit and the harm that come from using medications intended to treat patients. I know that abuse and its consequences at the individual level, at the family level, and at the societal level are devastating.

As the president of a company that develops and brings pain medicines to market, it might seem odd in some respects to hear me agree with my counterparts on the video conference. As a pain doctor it's my belief that in certain cases opioids in particular are over-prescribed. They're often prescribed for inappropriate conditions. That tells me we all have a lot of work to do.

That said, and to state the obvious, I do represent a company and I can't remove my affiliation. We're a company, and like any other business, we need the ink on our ledger to be black and not red. We need to do that because we employ just about 400 people in both Pickering, Ontario, and across the country. We need the ink to be black because we're in the business of developing medicines that require a substantial investment, and those medicines are intended to benefit patients and provide a public health benefit.

I'm encouraged that earlier in the week the federal government delivered an economic action plan in the House of Commons. It's my understanding that this plan will expand the focus on drug abuse from illicit drug abuse to abuse of prescription medicines, and I think that's just fantastic. We can't stress enough and can't educate enough at all levels things such as safe use, proper storage, and proper disposal of medicines that carry this risk.

I know, and many organizations with learned individuals know, that medications, opioids in particular, that fall into the wrong hands and that are abused and misused often come from the very medicine cabinet of a legitimate patient who is seen in a doctor's office. We need to do something about that.

With that, I applaud the efforts of this committee. I congratulate those here in Ottawa and across the provinces who have already taken action on this issue.

For the remainder of my time, I intend to offer as a resource my company's experience with OxyContin, with a product developed to address a specific vulnerability, OxyNEO, and to share how we went about doing that, how we worked with the regulators, particularly in the United States where I come from, and then of course to answer questions.

I'm happy to take questions about my company, about what we've done, but it's my view we're here to discuss prescription drug abuse. This isn't a single company issue. It's not a single product issue. It's a public health issue. As a pretty high-ranking official at the U.S. FDA refers to it, it's a public health crisis.

Before coming to Canada in September of last year, I was the chief medical officer at Purdue in the United States, a position I held for roughly five years. I headed clinical development. Most of my responsibility was to oversee the development of opioid medications that were designed to be safe and effective for patients, but that would also have another benefit—they would be less attractive as drugs of abuse. One of those products is actually OxyNEO here in Canada. We still refer to it as OxyContin in the United States, because we determined the recognition associated with that name would have doctors retain the state of awareness for how careful one needs to be in prescribing it to patients.

● (0920)

The product it replaced—OxyContin, which has been referred to already—was deemed by Health Canada, the U.S. FDA, and many other health authorities around the world as safe and effective when prescribed to appropriate patients and when used as directed. It delivered medicine, oxycodone, as an active ingredient over 12 hours.

It really did revolutionize, from a practitioner's perspective, the treatment of pain for folks with cancer pain and non-cancer pain that was chronic, moderate, or severe in nature. It allowed patients who had previously been taking oral medication four, six, or eight times a day to take it twice a day. That's pretty meaningful if you suffer from chronic pain. Fortunately, I'm not a chronic pain patient myself.

While the medicine was safe and effective, it did have an Achilles heel, a specific vulnerability. The vulnerability that we didn't anticipate, that could track and lead to the type of abuse and outcomes that we heard about just a few minutes ago, was that it could be easily crushed. Within a matter of seconds, one could, under this glass or between two spoons, crush this pill and access 12 hours' worth of opioid pain medicine. Intended for delivery over 12 hours, it could be readily accessible.

To abusers who were seeking an opioid, that was terrific. To patients, thankfully far less often than abusers, it could also mean a bad outcome. Some patients—we have a record—in need of pain control here and now would on occasion chew the medicine to get pain relief more quickly than they would receive if they swallowed an intact tablet. As well, without knowledge, when an otherwise well-intentioned caregiver in an institutional setting would crush a tablet and administer it through a nasogastric tube, or an orogastric tube, because patients were unable to swallow medicines, bad outcomes would occur.

Before getting into OxyNEO, and certainly before concluding my remarks, I want to make four points for context. First, as I'm speaking about abuse-deterrent formulations, or ADFs, and the movement from OxyContin to another product, OxyNEO, I want to make the point that abuse-deterrent formulations are not a silver bullet. Abuse and addiction are very complicated matters. They're multifactorial. There are sociological, economic, behavioural, and genetic components that need to be approached from multiple dimensions.

Second, abuse-deterrent formulations are just that: intended to deter abuse, not eliminate abuse. There's no technology available to us today—to Purdue or any other company, large or small—that is abuse-proof or that is abuse-resistant. The idea is to create a barrier and to send the folks who would otherwise abuse this product somewhere else.

Third, abuse-deterrent formulations are an incremental but essential improvement on products that have been around for a very long time. Companies like Purdue can and should pursue them.

Fourth, abuse deterrence isn't a branded versus generic drug industry issue. I'd like to say that again. It's not a branded versus generic issue. Branded and generic companies have technology and laboratories available to them, and both parts of the industry should be pursuing this. This is about public health.

OxyNEO, like most medications, was designed for patients. The benefits of making them safer for patients are obvious. On the abuse side, the benefits of making them less attractive to abusers are less obvious. But if a product is less attractive to abusers, it could mean less doctor-shopping, less diversion, and less theft or criminal activities related to obtaining it. Certainly, with those less affected, it means less emotional, societal, and financial burden associated with abuse.

We formulated OxyNEO specifically to address two routes of administration that are particularly harmful and particularly attractive, especially to those who prefer opioids for a long time—intranasal abuse and intravenous abuse, two particularly dangerous routes of administration. With a different excipient and a unique manufacturing process, we were able to make these tablets, which had been easy to crush, very hard, very difficult to crush, and very difficult to reduce to smaller particles for the purposes of swallowing, snorting, smoking, or injecting.

● (0925)

It took my company nine years. We started this exercise in 2001 or thereabouts. It took us nine years. We pursued four or five different drug-delivery platforms, spent many hundreds of millions of dollars, particularly in the United States, until in 2005 we came upon this technology that would allow us to replace the OxyContin product with one that would be equally safe and effective for patients. It would be therapeutically interchangeable, but have this added benefit of being more robust to manipulation, whether it be for the purpose of intentional abuse or inadvertent misuse by patients.

What did we learn? In August 2010 we transitioned the United States market, and most of our experience is from the United States because it happened earlier there. We've learned a lot. We've learned that while the product can and is still being abused—and I want to be clear about that—abuse has gone way down relative to the abuse we saw with the original OxyContin product, particularly because it's difficult to crush, it's difficult to snort, and it's difficult to inject.

Yes?

The Chair: Our time is up, so if you could just conclude in a minute or less, that would be terrific. Thank you.

Dr. Craig Landau: No problem.

What have we seen? We've seen a 73% reduction in non-oral abuse: injection, snorting, and smoking. We've seen a 33% reduction in oral abuse. We've also seen a reduction in outcomes that are surrogates for abuse. Diversion is down, criminal activity associated with OxyContin is down, as are pharmacy thefts. We've seen less doctor-shopping and fewer cash payments for high-milligram strength prescriptions, all surrogates for abuse.

Trumping everything is that fewer people have been dying as a consequence of OxyContin, especially in those cases reported to involve tampering in the context of abuse. All of the data in their totality—and I'm finishing up—were the basis for FDA, the U.S. health authority, to make two determinations. First, the OxyNEO formulation does in fact have features intended to deter or expected to deter abuse, and second, that the benefit-risk profile of the original product, which was easy to crush, was no longer considered favourable. That decision essentially barred “easy to tamper with” versions of controlled-release oxycodone from entering the U.S. market for sale.

We think that was a tremendous victory for public health in the United States, and while it's not a silver bullet, I'm here as a resource and I put my company behind me to answer questions and to do what we can to achieve the same outcome here in Canada.

Thank you very much, Chair.

The Chair: Thank you very much, and thank you for your service. In light of the fact that we're in the middle of the Olympics, I wish both your men's and women's hockey teams all the best getting a silver medal. Gold is unlikely, but we hope you get silver.

Some hon. members: Oh, oh!

The Chair: As always, again I'll just remind all our members of Parliament to please ask your questions succinctly and allow our guests to respond so that we can get the answers in. I'd ask our witnesses to respond in a succinct manner so we can get as many questions in as we can.

We have a seven-minute round, and first up we have Ms. Davies. Go ahead, please.

● (0930)

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

Thank you to the witnesses today.

It's been quite a fascinating discussion, and I thank you for being, I think, very honest about where addictions are in Canada in terms of our view. I agree, Dr. Durnin, that there's a great stigma attached, so I think some of the honest remarks that you made were very refreshing to hear.

Thank you for getting up so early in the morning in B.C. Being from B.C., I know what that feels like, so thank you for the fact that you're here and alert, both of you.

There are so many questions.

Dr. Persaud, about the information that you provided us in terms of the educational session you went to that was sponsored by Purdue Pharma, when you were speaking about the lower abuse claims and how these were false, was that based on OxyContin, or is that also based on the new product OxyNEO?

Dr. Navindra Persaud: I was talking about the marketing of the older product, OxyContin. I would like to say regarding the newer formulation that it's remarkable, given the history—that is, the history of Purdue Pharma illegally making the claim in the United States that its product, OxyContin, which was the newer formulation at the time, had a lower abuse potential—that still today Purdue Pharma seems to be singing the same tune; i.e., saying that this even newer formulation that they have today has a lower abuse potential. I think that it's likely to result in exactly the same problem.

Ms. Libby Davies: If I understand it then, you're still concerned that the newer product still is making claims that may not be correct, so physicians may end up prescribing too much, too high a dose. There may still be a high potential for abuse. Is that correct?

Dr. Navindra Persaud: Exactly. Added to those potential problems is the concern that the new medication would be prescribed to people who may not need to receive a prescription for opioids at all. Physicians might decide to write a prescription for OxyNEO, believing there is a reduced potential for a patient who does not need a prescription for opioids at all.

Ms. Libby Davies: I find it very interesting because when we began this study I remember asking some questions about marketing because it seemed to me that there was no independent assessment. So you have this very close relationship, as you've described, between pharmaceuticals and physicians, and there's really nothing in between even though, allegedly, Health Canada does give some oversight. But as you pointed out, it's sort of a passive kind of thing. That is very concerning because we're talking about a multi-billion dollar industry here. We're talking about the real health interests of people.

The question I'd like to get at is what do we need to do to bring in a much tougher regulatory system. We've had vague promises and commitments, but the fact is that the system is not in place. Who provides that monitoring? Presumably it should be Health Canada. Their role is to ensure drug safety for Canadians, yet there is a huge vacuum. That's not being done.

It would be very helpful, Dr. Persaud and Dr. Kahan, if you could be a little more specific about what you want to see us recommend concerning a much tougher regulatory system with regard to what's being put out there, and some assessment as to whether or not these products are actually open to abuse in terms of what's being said in the claims, and whether or not they are safe.

Dr. Meldon Kahan: The two most important things are, first of all, to ensure that the product monographs are objective and are not influenced by pharmaceutical marketing. The product monograph is listened to by physicians. It's in the CPS. Physicians are expected to adhere to it, and it is the basis for advertising and future claims. The product monograph for OxyContin was inaccurate, and the product monograph for Hydromorph Contin, for example, is similarly inaccurate in many ways. That's also a Purdue Pharma product.

So that is number one. The product monograph should not be approved by Health Canada without an independent, objective review.

Second, it is up to educators, medical schools, residency programs, and accrediting bodies such as the College of Family Physicians of Canada, to ensure there is no pharmaceutical influence on the content of the messages. It is unacceptable that Dr. Persaud was confronted with an educational program sponsored by Purdue Pharma and presented by a medical regulator. That is truly a conflict of interest.

Finally, medical authorities, the medical regulators, the colleges of physicians and surgeons, should make explicit prescribing standards. They should say what they expect of physicians in terms of the indication for opiates, who should get them, what are the doses, what is the screening, and what other precautions need to be taken. That needs to be taken outside of the pharmaceutical industry. It needs to be taken out of the hands of pain specialists, who sometimes also have conflicts of interest, and to be put in the hands of medical authorities.

● (0935)

The Chair: You have 45 seconds.

Dr. Navindra Persaud: I agree with all those suggestions and I'll just list a few more, if it pleases the committee.

First, at the stage of approval of medications, there should be higher standards for new products being approved. I think that currently there are too many different drugs that could potentially be abused, and in particular, too many opioids that are currently marketed in Canada.

The promotion and marketing of pharmaceuticals in Canada should be monitored proactively by Health Canada. They should not await complaints. That will of course require additional resources for Health Canada. They currently, I understand, do not have the resources to proactively monitor the marketing and promotion of medications.

Certain marketing practices should be banned.

You were quite right, Ms. Davies, when you said that there's a large challenge. Several billion dollars are spent by pharmaceutical companies in Canada every year. Estimates range from between $2 billion and $5 billion a year. It's difficult to counter that with medical education, so I think certain practices should be banned.

That would include visits from sales representatives to physicians. There is no good reason for those to take place. Samples should be banned. Sales representatives drop off samples of pharmaceuticals to physicians. Again, there is no reason for them, and in the end, patients end up paying for them.

There should never be any influence from pharmaceutical companies in the curricula of medical schools or in continuing medical education sessions. That should be completely banned and is something that the government could have a role in banning. Certainly, colleges such as the College of Family Physicians of Canada should not accredit educational sessions that are funded, sponsored, or influenced by the pharmaceutical industry.

Finally, Health Canada should also monitor for the harms, as I mentioned in my remarks. They currently don't have the resources to do that, as I understand it, but for particular medications where there is a risk of abuse, such as opioids, Health Canada should be able to say how many deaths there have been in Canada and at least provide estimates of the number of people dependent on the medications.

Finally, in order to set an example and to generate revenue for these investigations, past wrongdoings should be investigated. As I mentioned in my remarks, Purdue Pharma was investigated in the United States and ended up paying $634 million—I believe that was the amount—but nothing so far has happened in Canada. It actually sends exactly the wrong message to pharmaceutical companies in Canada. It says that it is easier here to market medications and that the regulations here are less strict.

The Chair: Thank you very much. We're way over time, but I wanted to let you get your points in before we conclude.

Ms. Adams, you have seven minutes.

Ms. Eve Adams (Mississauga—Brampton South, CPC): Thanks very much, Chair Lobb.

I'd like to thank everyone, all of the witnesses and all of our members

Today constitutes the last day of our study on this subject, and I think all members of this committee were heartened to see that the economic action plan proposes to invest almost $45 million for this very subject. We'll be expanding the national anti-drug strategy to include prescription drug abuse. It's pretty clear that the government has been paying attention to the hard work of all our committee members, so that was very welcome news.

According to the National Advisory Council on Prescription Drug Misuse, women may be considered an at-risk group for prescription drug abuse because they're more likely than men to be prescribed to for non-medical reasons, such as coping with stress or grief, or apparently, for adjusting to childbirth or menopause.

Perhaps I can turn this question to Dr. Durnin-Goodman. I was particularly impressed by your very practical advice in treating those with substance abuse. Based upon your research, do you find that women are over-prescribed to? Is this an issue?

I read this and found it incredibly patronizing, to be frank with you, but by the same token, if there is a real phenomenon, I think we need to be turning our attention to it.

● (0940)

Dr. Maire Durnin: I'm going to say that I live on the north shore of Vancouver, which is a middle- to upper-class area, and my impression from speaking to family doctors in that area is that there is a problem. I've had family doctors tell me that women, especially, will order their medication online. It will come over from the States, and that's not picked up on. They will pop it at parties, whether it's oxycodone or a benzodiazepine such as Valium, and they'll have it along with their glass of wine and "off we go". However, what I am more concerned about, to be honest, is the pervasive use of sedative-hypnotic medications, which I find more damaging or more difficult to deal with in women, for whatever reason. That's not a statistical thing. That's my personal observation.

Women, as you know, cope with stress at both ends—at home and at work, with the kids, etc. They do the double shift and they have to find ever-increasing ways of coping. We don't support, as a system, the other means of coping that we know are healthier, such as cognitive behavioural therapy, etc. We don't have the time to do that in our society and that's why people turn to these medications. They don't perceive them as problematic. Yet they are hugely problematic as we've talked about. Whitney Houston and all of these people used benzodiazepines daily in their lives.

I'm sorry—I forget the rest of what you were talking about. I just get so upset about this.

But the other thing I wanted to say is that you heard from other speakers earlier on that there is a huge problem with opiates and benzodiazepines in our addicted population, and those are the cause, for example in B.C., of probably at least, I'm going to guess, about half of the overdose deaths that we see.

Ms. Eve Adams: That's unbelievable.

We're looking at some of these statistics, and even the economic action plan cites, I think, one of the most compelling pieces. There's been an increasing rate of prescription drug abuse, which doubled amongst Canadians aged 15 and older in one year, between 2011 and 2012. This is an epidemic.

Dr. Persaud, apparently there are these tamper-proof medications being brought forward. I've been hearing reports that they're fairly easy to circumvent and that you can microwave them and then inject the substance. Are there ways to circumvent these tamper-resistant drugs? If not, don't addicts just switch to some other drug?

Dr. Navindra Persaud: Thank you for the question.

Yes, absolutely. As the president of Purdue pointed out, no formulation is completely resistant to tampering, and even the newest formulation, of course, can be altered so that it can be injected or nasally insufflated, nasally inhaled. But even aside from that, the pills are designed to be swallowed. One way to harmfully misuse opioid medications and other medications like benzodiazepines is simply to swallow the pills, to swallow more than the prescribed amount or to swallow pills that you are not prescribed. There are some studies of people who have died of overdoses suggesting that actually in only a small fraction of deaths from overdose is there evidence of injection or nasal insufflation of the medication. The inference is, in many cases, that individuals are simply swallowing pills.

Ms. Eve Adams: While I certainly appreciate many of your comments, there was one that I took exception to. That was that you thought there was no good reason for samples to be distributed through a physician's office. I would just humbly suggest to you that I wouldn't want to throw out the baby with the bath water. There are many people who don't have drug plans, for instance, working-class people or small-business owners. So I think there might be many legitimate uses for samples.

But I think you were bang on in saying that continuing professional education should never be sponsored. Is the one certificate you brought with you an anomaly or is this something that is actually taking place across the country?

● (0945)

Dr. Navindra Persaud: Thank you for the question.

It's definitely not an anomaly. If you go to the annual conference of family physicians, you will meet with representatives of all of the pharmaceutical companies present in Canada. It's very common for continuing medical education events to be funded or sponsored.

Ms. Eve Adams: Dr. Persaud, do they happen to be there at that conference or are they actually putting on the educational sessions?

Dr. Navindra Persaud: They host satellite symposia at conferences. They also host hospital rounds or sponsor hospital rounds presentations, just like the session I attended in 2010. This would be an hour-long presentation, usually in the morning, at which physicians meet to discuss a particular clinical topic. Those are commonly sponsored by pharmaceutical companies. They also happen at lunchtimes in clinics and they are sponsored by drug companies that often bring lunch. It's very common.

Ms. Eve Adams: There's a sort of hospitality add-on.

Thank you very much.

The Chair: Thank you.

Our next stop for seven minutes is Mr. Scarpaleggia.

Go ahead, sir.

Mr. Francis Scarpaleggia (Lac-Saint-Louis, Lib.): Thank you very much.

Thank you to the witnesses for your presentations. I'd like to start by saying that we're disappointed with the decision of the chair to direct the clerk to disinvite Nova Scotia Minister of Health and Wellness Leo Glavine yesterday afternoon, overruling the witness list that was distributed to members on November 29 of last year as described in the *Minutes of Proceedings* of the November 27 meeting.

This is particularly concerning given the minister's unique expertise and work in the very field we are studying. We hope that this decision is not politically motivated since he is the only witness who was disinvited and the chair has substituted him with another witness who had requested to appear. He did this despite Minister Glavine being one of our top priority witnesses.

Ms. Eve Adams: I have a point of order.

The Chair: We won't eliminate your time but we have a point of order.

Mr. Terence Young (Oakville, CPC): That was his time.

The Chair: No, the time used on the point of order.

Go ahead, Ms. Adams.

Ms. Eve Adams: I have a point of order.

Mr. Chair, I don't believe this is actually pertinent to the discussion at hand. I think the witnesses who are and are not called are conceived of in a different manner. I would respectfully suggest to the member to direct his questions to the witnesses who have taken the time to join us here today.

The Chair: Mr. Scarpaleggia.

Mr. Francis Scarpaleggia: There are no specific rules apparently governing the nature of questions that may be put to the witnesses appearing before committees.

So if I may just continue with this I'll be done in a couple of seconds and I'll go on to my questions.

I would ask the clerk to invite Minister Glavine to submit his remarks to this committee so that members may review his testimony.

I'm new to this committee. I'm not normally a member of this committee. I'm substituting for Dr. Fry, and I find this study quite fascinating actually. So you'll have to excuse me if some of my questions appear rudimentary to those who have been part of the study all along.

I'm trying to get a handle on this notion of prescription drug abuse. I've been thinking about it a lot because of ads that have been running, at least in my province, and I imagine there are ads sponsored by the provincial government about this problem. I really wasn't aware of it in total until these ads started to appear. Now this follows up on these ads.

Perhaps you could explain to me, Ms. Strang, what is really involved. Are we talking mostly about opioids? When we talk about prescription drug abuse I imagine that people aren't stealing cholesterol drugs or what have you. We are dealing with painkillers. I guess that's what it's about.

Ms. Lorinda Strang: As Dr. Durnin also mentioned, we work together at the Orchard Recovery Center. We see, for theft and fraud, it's often the opioids but it's also benzodiazepines as well.

Mr. Francis Scarpaleggia: Would that be Valium?

In terms of the mechanics of this, how does it happen? I understand there can be theft and people can take too much of the drug that has been prescribed to them. But then they would have to renew their prescription and typically doctors give limited refills and so on. Of course, others in the household can raid the cabinet no doubt, but other than those methods how do people get their hands on these, other than, as I say, breaking into pharmacies and so on? You talked about requiring an ID to get a prescription drug from a pharmacy. Could you just elaborate on that because, as I say, I'm new to the study and I'm not familiar with all of it.

● (0950)

Ms. Lorinda Strang: There are two streams. There are people who are legitimately prescribed medication for a broken ankle or a surgery or whatever, or benzodiazepines for anxiety. There are people who can use those and not become addicted. Then there are people who become addicted to the medications after they have been legitimately prescribed them. At that point they become addicted and dependent on those medications. That is when they start to lie to their doctors. That is when they start to steal or change the prescription medications, adding an extra zero to the prescription will give them extra medication. There are a million ways that they are trying to circumvent the system.

Then there are people I've talked to who've heard that there's a whole generation out there right now that has just started to use prescription medications to get high. There's a whole culture among our youth who believe it's safer to get the medication from the doctor. They're mixing it with other things, they're crushing it and shooting it, they're lying and manipulating their doctors because they've become addicted to it.

So there are the people who are just using these medications to get high, and then there is another stream of people who were legitimately prescribed the medication, became dependent upon it, and then manipulated the system.

Mr. Francis Scarpaleggia: In stealing it, you have to manipulate your doctor or lie to your doctor.

Dr. Maire Durnin: There's a huge street market for OxyContin and other opiates and benzodiazepines, and it comes from everywhere. It comes from over the border. You'd have to ask the RCMP, but it's out there. It's manufactured. We have pharmacy break-ins in British Columbia all the time. We have doctors who are overprescribing.

You also need to remember that once someone becomes addicted, they need some kind of opiate. So when OxyContin or street OxyContin and now fentanyl become too expensive, they will turn to heroin. So our young people in this age group are now finding they can't afford the $500 to 600 a day to maintain their Oxy habit, and they will turn to heroin because it's more potent and cheaper. Then they inject—you get HIV, hepatitis C, and I see that now regularly in my practice. My colleague has a patient who's 16 years old, and I have several who are 18 or 19.

Mr. Francis Scarpaleggia: I understand.

How much time do I have left?

The Chair: You have about 15 seconds.

Mr. Francis Scarpaleggia: I'll stop there.

The Chair: Thank you.

I'll just pass along from your initial comments that we'll certainly welcome Mr. Glavine's comments. We'll make sure the analyst takes his comments and his suggestion for the report.

Ms. Libby Davies: On a point of order, Mr. Chair, I'm wondering if we could get an explanation as to why the minister from Nova Scotia was not on the list, and why we ended up with a new witness, Dr. Landau, whom we've already heard. What happened?

The Chair: It's not a point of order, but we can discuss that in camera after the meeting. We have our time here now, and I'm happy to discuss that with you later if you'd like. It's up to you.

● (0955)

Ms. Libby Davies: Is there a reason you can't tell us in public?

The Chair: No, I can tell you right now if you want.

Mr. Glavine is an elected official. He was put into the position in October. He was put forward as a witness by someone on this committee. That in itself is not a problem. The reality of the situation is that it was probably more appropriate for a deputy minister or a subject matter expert inside the ministry to present. That's why I say we'll welcome his proposal, his submission, at that time. That's the chair's prerogative. Right or wrong, that's the prerogative I took, and that's the explanation.

Ms. Libby Davies: How did Dr. Landau get on the list? He wasn't on the list yesterday, nor in the notes we got, so we had no background.

The Chair: That's a good question too. Again, some of these things happen on the fly. They were on the list. They were there; they were supposed to be in on Tuesday but couldn't make it. They were able to make it on Thursday. That's the long and the short of that one.

Ms. Libby Davies: Thank you.

The Chair: Okay? Good.

Mr. Young.

Mr. Terence Young: Thank you, Chair.

My question's for Dr. Landau.

Dr. Landau, in the late 1880s Bayer in Germany created a synthetic opioid that made people feel heroic. They marketed that drug to treat pain, and for those who were addicted to morphine or the liquid version, which is laudanum. They did it by telling doctors with no clear evidence that it was safer than other such drugs because it wasn't addictive.

That drug was heroin, one of the most addictive drugs in the world, which has caused immeasurable misery to addicts ever since. It has ruined tens of thousands of lives, caused thousands of deaths, and cost hundreds of millions to health care plans worldwide.

Flash forward to the late 1990s. Your company, Purdue Pharma, did the exact same thing with oxycodone/OxyContin, sending out an army of detail reps to persuade thousands of doctors with no clear evidence that it was safer than heroin or morphine, and it wasn't really addictive. Now you're here today doing the same thing for OxyNEO.

Your company financed and co-opted a professor at one of the finest medical schools in Canada for a compulsory week-long curriculum on how to treat pain. You provided him with false information for those lectures in the form of free textbooks paid by Purdue Pharma that indicated that oxycodone and OxyContin were not addictive in the absence of clear evidence. You provided free copies for his captive audience of medical students.

The text amended a WHO document, World Health Organization, that did not mention oxycodone, to add oxycodone and indicate that oxycodone was a weak opioid similar to codeine and tramadol—when the truth is that oxycodone is at least 1.5 times stronger than morphine—thus making oxycodone appear safer than it was.

You arranged for the CMAJ to print a review of a clinical trial that said there is now evidence opioids relieve chronic, neuropathic, and nociceptive pain." Instead you added in three words "strong and consistent" evidence opioids relieve chronic, neuropathic, and nociceptive pain, thus grossly exaggerating the efficacy of oxycodone. All this to persuade a new generation of doctors that oxycodone is more effective and less powerful, and therefore safer for patients, and less likely to cause addiction.

Oxycodone/OxyContin is now well known as the most addictive drug in the world, which has created thousands of addicts whose lives have been disrupted or ruined, many of whom have turned to crime to pay for their oxycodone/OxyContin habit in some cases becoming addicts for life, hundreds of others turning to crime to pay for their Oxy, and in many others dying from overdose.

In May 2007 your company in the U.S. paid $634.5 million to the U.S. government in fines for illegally marketing oxycodone/OxyContin.

I'd like to ask you what are the total worldwide sales for these two drugs since you started selling them just in billions of dollars.

Dr. Craig Landau: Thank you for the question. I don't know, unfortunately.

Mr. Terence Young: It's billions of dollars certainly. How many billions? Can you give me a rough....?

Dr. Craig Landau: It's hard to know given that timeframe.

Mr. Terence Young: Is it $3 billion, is it $13 billion, is it $23 billion?

Dr. Craig Landau: I'm honestly not certain. I don't know. It's in the billions of dollars for sure.

Mr. Terence Young: Thank you.

Dr. Landau, considering Purdue Pharma's aggressive and corrupt marketing practices in Canada, and the severity of the addiction problem it has caused with 500 deaths in Canada as we heard this morning, thousands of lives ruined, and the massive cost to federal and provincial health plans, would Purdue Pharma apologize to Canadians and put $45 million on the table, just like you put $634.5 million on the table in the US, but this time for treatment programs for those who have been addicted to opioids, some of them the first time they took the drug?

I am asking Purdue Pharma to match the $45 million our government put on the table in the recent budget to help relieve some of the misery, and help these people get off your drugs.

Dr. Craig Landau: The question is will we...?

● (1000)

Mr. Terence Young: Would you match the $45 million our government has committed to deal with problems your company created with illegal marketing to help these patients, treat them, and get them off addictive drugs?

Dr. Craig Landau: Thank you for the question.

I'll take the request back with me. I'm not in a position to say yes or no at this point.

Mr. Terence Young: I have another question. Since there are 200 painkillers on the market including morphine and heroin, which have known safety profiles certainly, why does OxyContin or oxycodone have to even be on the market? With all the misery you have caused, why don't you just take it off the market and have a special access program for those who are addicted to it?

Dr. Craig Landau: Thank you for the question.

OxyContin, since it was introduced, has brought benefit to tens of millions of patients in North America for sure and beyond.

Mr. Terence Young: There are lots of other painkillers that could have benefited those patients.

Dr. Craig Landau: That carries some more abuse liability, sir.

We are very interested, if I can take a step back and respond to your question.

Mr. Terence Young: I'd like a brief answer, please, because my time's so limited.

Dr. Craig Landau: A brief answer to which question?

Mr. Terence Young: There are 200 painkillers on the market, including ones with known safety profiles. We know the dangers, the risks, and the harm that OxyContin and oxycodone have caused. Why don't you take it off the market and call it a day, and have special access for those who are addicted to it?

Dr. Craig Landau: As I mentioned, OxyContin brings tremendous benefits to patients. These medicines are designed for patients. Physicians like myself require options for patients—

Mr. Terence Young: Does it do anything for patients that the other painkillers on the market couldn't do?

Dr. Craig Landau: At the individual level, that's up to a physician to determine, because patient care needs to be determined on an individual basis, something Dr. Persaud and Dr. Kahan would agree with.

Mr. Terence Young: You talked about appropriate patients. Is an 18-year-old who goes to get their wisdom teeth out an appropriate patient for OxyContin?

Dr. Craig Landau: No.

Mr. Terence Young: Have you ever written a letter to the dentists in Canada and recommended they do not prescribe oxycodone or OxyContin for young people getting their wisdom teeth out?

Dr. Craig Landau: To my knowledge, Purdue Canada has never detailed dentists or recommended their use.

Mr. Terence Young: But you're well aware they're using it. They're big prescribers. Have you ever written a letter saying you don't recommend this?

Dr. Craig Landau: I'm not aware that dentists are big prescribers of OxyContin.

Mr. Terence Young: I can tell you they are. Because I know young people who have had their wisdom teeth out—two in my riding—and are now addicted to OxyContin. Their parents drive them to Burlington twice a week to get methadone, because their dentists gave it to them when they had their wisdom teeth out.

Dr. Craig Landau: Well, that would be inappropriate prescribing. I would agree with you.

Mr. Terence Young: Have you ever told dentists, in any way, that it's inappropriate to prescribe oxycodone and OxyContin for young people getting their wisdom teeth out? If you haven't, why not?

Dr. Craig Landau: I'm not certain if the company has actively visited dentists to tell them not to prescribe a medication or not.

Mr. Terence Young: It doesn't matter if they've been there or not. The dentists are prescribing it; you're well aware of that. You know the sales profiles of your drugs. Have you ever told them, don't do this, it's not good for our young people? Because you're creating addicts. That's negligence, in my opinion.

The Chair: Mr. Landau, a brief response because we are out of time.

Dr. Craig Landau: As I mentioned, I'm not aware if we have or haven't visited dentists to offer that message. But it's something the company could and should consider.

The Chair: Okay, thank you very much.

For our next round, we're into our five-minute rounds here. Next we have Mr. Morin and he's going to present his questions in French.

[*Translation*]

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

My questions are addressed to Dr. Durnin-Goodman and Ms. Strang.

I liked your presentations very much. You shared an interesting perspective with us. I believe, Ms. Strang, that you are the one who mentioned that there is widespread ignorance in the population in general, and even within certain political bodies, when it comes to dependency. I am referring to prescribed medications that are considered as drugs, as well as to their consequences on the lives of those who become dependent on them. Let us hope that these people will eventually become patients who will receive the treatment they need.

Do you believe that the Conservative government's approach to people who are dependent on prescription drugs is appropriate?

In my opinion, in its fight against drugs, the Conservative government is adopting the wrong approach in blaming persons who have a substance dependency, such as a prescription drug addiction. I feel it is...

● (1005)

[*English*]

Mr. James Lunney (Nanaimo—Alberni, CPC): I have a point of order.

With all due respect, Mr. Morin, the witnesses here are experts in treating people. I think it's inappropriate to ask them questions that are clearly of political strategy in origin and to comment on political approaches. It's clearly inappropriate.

What we're asking here today is how they manage these people.

Ms. Libby Davies: That's not a point of order.

Mr. James Lunney: I would think, Mr. Chair, with all due respect, that you would call on the witness to direct his questions in a manner that is appropriate to the purposes of the committee meeting.

The Chair: Thank you, Mr. Lunney. That's not really a point of order.

Mr. Morin, carry on.

[*Translation*]

Mr. Dany Morin: I will continue on that topic, then. If Ms. Adams wants to talk about the approach of the Conservative government to the abuse of prescription drugs, I think I can do so as well in my questions.

You have heard my questions. What do you think of the Conservative government's approach to its fight against drugs, including prescription drugs? In your opinion, is that the best approach, or should the government change its perspective?

[*English*]

Dr. Maire Durnin: That's a very difficult question for me to answer, because I'm not sure what the whole approach entails. I'll give you a generic version of what I think we should be doing.

Number one, I think there needs to be a firewall between pharma and doctors. In other words, pharma contributes to funding for research and education of doctors, but that should be a common fund that helps to educate. They do not direct the education. It comes from individuals such as Dr. Kahan and Dr. Persaud, who can provide evidence-based information to train our doctors.

Secondly, the prescription issue itself needs to be controlled.

Thirdly, you mentioned stigma. I think that is a huge factor that is lacking.... As we've talked about before, stigma is massive, and it needs to be addressed. The level of ignorance.... I have doctors not doing surgery on my patients because they're on methadone, doctors making excuses not to do it. I have nurses telling my pregnant patients that they shouldn't be on methadone, when in fact we know that this is a safe, effective, and recommended treatment. I have other addicts who tell my patients that because they're on methadone, they're not really clean and sober.

That's just within the people who should know better. When it comes to the public...and I've heard some questions in this forum that indicate clearly there's a great deal of misinformation out there. I think that's what this government needs to direct its attention to in order to educate people on what is going on and to educate them correctly, through people like me, like Dr. Kahan, etc., and like Lorinda, people who have been there and done that, who are in the trenches, and who can really explain to people what's going on. We would invite you to come to our places of work to see that.

Mr. Dany Morin: Do you have any concrete ways for the government to spread that information? You mentioned health professionals who might not have accurate information and also the general public. Based on the fact that we have a pan-Canadian government that has a lot of ways to reach Canadians, do you know concretely how the Government of Canada could do this?

Dr. Maire Durnin: I think that's a matter for further discussion around here, but you need a panel of people who can speak to, for example, the language used in addiction, which is massively important. On the terminology you use, the best analogy I can give you in terms of the stigma and the way we approach it is where we are with homophobia these days, compared to where we were 30 years ago. The analogy is very strong, although homophobia is not an illness, and this is.

I think you need to have a committee of educated individuals who can direct a campaign, such as the take back prescription drugs day that's already occurred. That's the direction that I think this kind of education should take: national campaigns, teaching in schools, and education by people who are qualified to give that education, not by lay individuals.

● (1010)

The Chair: Mr. Lunney, you have five minutes.

Mr. James Lunney: Thank you, Mr. Chair.

Thank you to all the witnesses for being here as we wrap up a really important study. You can see there's a lot of interest in the subject matter.

Dr. Landau, I just wanted to express, you made some admissions in the beginning of your presentation that you agree that opioids are sometimes over-prescribed, perhaps inappropriately prescribed. Your conclusion was that we all have a lot of work to do.

It was other witnesses who brought forth the fact that your company actually did pay a pretty substantial fine for a misleading advertising campaign. I just find it rather astonishing and perhaps disappointing that in your defence you mentioned the 400 employees in Pickering and that ultimately, as the president, it's your responsibility to ensure that the ink is black and not red.

I just thought it might have been helpful to acknowledge that your company was in fact responsible and convicted of a very serious problem in the United States and there's action pending in Canada as well. Having said that, I'll just leave that for you to think about.

I want to move on to Dr. Persaud. You brought up some very interesting points about where physicians get their information on prescribing. I'm very interested in the remedies that you both, our Toronto witnesses, brought forward. I'm aware that you mentioned the advertising campaign, the clearly inappropriate advertising and misleading campaign, that Purdue conducted.

But when physicians are asked, according to polling, where they get their prescribing information, what's their most reliable source? Is it the drug reps? Is it the product monographs? I think the most common answer, according to one poll that I saw, was actually the ads that are in the peer-reviewed journals and in the CPS, the Compendium of Pharmaceuticals and Specialties.

Some of the slickest ads in the world.... I think the perception is that they're peer-reviewed. Of course the articles in the journals may be peer-reviewed, but the advertisements have never been peer-reviewed.

Would you agree with that assessment, that it's a particular problem? I think it goes along with some of the other comments you were making.

Dr. Navindra Persaud: I completely agree and thank you for the question. We recently completed a study that demonstrated that Canadian medical journals, such as the *Canadian Medical Association Journal*, when compared with journals in the United Kingdom and the United States, such as the *British Medical Journal* and the *Journal of the American Medical Association*, had five times the number of ads. Some issues of Canadian journals actually had more pages of ads than they did journal content.

There are many studies that have demonstrated that the content of pharmaceutical ads is misleading, and in some cases, even contains inaccuracies. The medications that are advertised in journals are different from the medications that are discussed in the peer-reviewed content of journals.

I completely agree with your point that this is an important area that could easily be redressed. Obviously the reason journals carry ads is to generate revenue, so we did a calculation of how much it would cost each recipient of the *Canadian Medical Association Journal* to have an ad-free journal instead.

Currently, Canadian physicians, who have an average salary of about $300,000 per year, pay just $12 a year for 18 issues of the *Canadian Medical Association Journal* delivered right to their door. In order to have that journal ad-free, it would cost only about $48 per year to have the journal delivered 18 times a year to the door of each physician in Canada.

So it would be very easy to make that change to ad-free journals and I think it would be an important step forward.

Mr. James Lunney: Thank you for that. That's a very interesting analysis that you've brought forward.

So who, primarily, would be responsible? The solution you put forward would be an ad-free journal in that particular example, which a lot of people would think would probably be very helpful.

But if there's going to be advertising in journals and in the CPS, who should primarily be responsible for reviewing those ads for accuracy to make sure there isn't misleading advertising going forward, very slick advertising, that is actually designed to misdirect people?

Dr. Navindra Persaud: It's currently the Pharmaceutical Advertising Advisory Board that has to approve every ad that appears in a print medical journal. I have had discussions with them about ads that I had concerns about, ads that I thought were misleading and could potentially harm patients and in cases where there's a concern about inaccuracies that could cause harm, the PAAB usually refers those cases to Health Canada. Health Canada's general position when I have communicated with them has been that they don't proactively monitor every statement that is made and they don't have the resources to do that.

So I would say the short answer is that the pharmaceutical ads are not effectively being regulated right now. There really isn't a body that's looking carefully at the content of pharmaceutical ads to make sure that they are accurate and that patients are being protected.

Medical journals are also receiving revenue from the ads and they have an interest in displaying ads regardless of how accurate they are.

● (1015)

The Chair: Ms. Morin is going to ask you a few questions in French.

So go ahead, Ms. Morin.

[*Translation*]

Ms. Isabelle Morin (Notre-Dame-de-Grâce—Lachine, NDP): Thank you very much.

I am going to continue in the same vein as my colleague.

Dr. Persaud, you said that in some countries the industry does not have direct contact with physicians. Could you tell us in which countries that is the case, and explain the regulation that governs this?

[*English*]

Dr. Navindra Persaud: Thank you for the question.

My comments may not have been clear. I'm not aware of any countries where there are no interactions between the pharmaceutical industry and physicians. I made some statements about.... I was contrasting the pharmaceutical industry here in Canada with other health care industries such as the medical testing industry.

Physicians routinely receive visits from sales reps of pharmaceutical companies and we are—to the last question—constantly being exposed to advertisements by the pharmaceutical industry. But if you contrast that with the medical testing industry, i.e. the companies that do blood tests and lab tests, they don't advertise in medical journals in general. They don't send sales reps to visit individual physicians. I was drawing that distinction in order to illustrate that industries can be profitable and they can contribute to the health care of Canadians without relying on marketing at all.

[*Translation*]

Ms. Isabelle Morin: Is that governed by regulations, or is it only a tendency? If it is governed by regulation, how could we implement that for pharmaceutical companies?

[*English*]

Dr. Navindra Persaud: I think certain practices should be banned or severely restricted, and that could happen at the level of medical schools. For example, that's the way to help control what happens when medical students and residents are taught. You could also work with national bodies like the Canadian College of Family Physicians. They routinely accredit continuing medical education programs that are sponsored by the pharmaceutical industry. I don't think that should be happening. I think all continuing medical education should be completely independent of the pharmaceutical industry, and those national bodies should never accredit such educational sessions.

[*Translation*]

Ms. Isabelle Morin: Thank you very much.

Dr. Kahan, in your statement, you mentioned that Health Canada's expertise in assessing the monographs published by the industry may not be adequate. You said that it might be good to entrust that task to independent experts.

Would it not be a better idea to strengthen the expertise within Health Canada, to make some adjustments, rather than calling on independent experts? Does that make sense to you? What would be the best thing to do?

[*English*]

Dr. Meldon Kahan: I personally think it would be better to have independent reviewers because there are so many hundreds of medications that it's impossible to believe that Health Canada could in itself have the internal staff to cover all these medications.

In 2010 we actually complained to Health Canada about the OxyContin monograph, and they simply wrote back and said it was not their jurisdiction to comment on the clinical accuracy of the monograph. I found that astonishing, actually, and it suggests to me that not only did they not have the expertise, but they don't think it's their job. I think it is their job or someone's job to say that what is in the product monograph has to be safe, true, and accurate.

● (1020)

[*Translation*]

Ms. Isabelle Morin: Thank you very much.

I have one last question for Mr. Landau.

There was a crisis in the United States that involved your product. Could you describe in a detailed way what the American regulatory bodies asked you to do? What obligations did they place on you?

[*English*]

Dr. Craig Landau: When the company in the United States first became aware of the problem—what became an emerging crisis of abuse—we met with the FDA frequently to share knowledge and to discuss plans to address the condition. We did put out at the time, although it was prior to my involvement, a multi-point plan that involved both the drug development activities that would ultimately produce the OxyNEO product nine years later, but also other risk mitigation activities that focused on education, proper prescribing, safe use, storage, and disposal initiatives, tamper-resistant prescription pads—we've heard other witnesses describe the benefit from these—law enforcement, and education. It was a multi-part plan.

I think most important to this discussion here in Canada is that we worked very closely hand in hand with the regulators and external experts in the United States to get to where we are today.

[*Translation*]

Ms. Isabelle Morin: Were you asked to do the same thing in Canada?

[*English*]

The Chair: Sorry, you're over your time.

Mr. Wilks, you have five minutes.

Mr. David Wilks (Kootenay—Columbia, CPC): Thank you, Mr. Chair.

My questions will be directed toward Lorinda Strang.

Thank you for being here today. Just on a personal note, you and I probably have two mutual friends in Bill Wilson and Dr. Bob Smith that you can probably relate to.

I want to go back to a very interesting point you brought up, and that was with regard to data from recovery centres that could be useful for our study. I'd like you to expound on that a bit, because I think we're really missing an opportunity here. You work at the grassroots level, right at the front lines. If we're going to get information, the best people to get it from is those who've been directly affected by it. I wonder if you could talk about that for a few minutes.

If I have any time left, Mr. Chair, I will divert it to Mr. Young.

The Chair: Thank you.

Ms. Lorinda Strang: Yes, I think we have a valuable resource in our early recovering clients who are going through medically assisted detox. We do also use medically assisted treatment protocols at the Orchard. Our goal is always abstinence for our clients. They cannot always get off of the medications in a short period of time, so we teach them tools in every area.

But with regard to statistics, I can tell you the peaks and the valleys, and what happens. OxyContin concern increased almost 167% in 2011. We saw a decline in 2012 and 2013, dropping almost 41% in those two years. Then we see an increase in fentanyl patches. We see all the different drugs of abuse, and we see the patterns and the trends, which can probably be directly related to the marketing of these medications as well.

We have that information. We have information on even zopiclone being a drug of abuse. Pharmacies and doctors may not even be aware of this. I think it's becoming more readily accessible knowledge now, but several years ago they believed that zopiclone was non-addictive and non-habit-forming.

We can tell you straight from—

Mr. David Wilks: Perhaps I can interject for a second, Lorinda.

Mr. Chair, if any of this information is available and can be provided to the committee for further evaluation, I think it would be greatly appreciated.

The Chair: Yes.

Ms. Lorinda Strang: I have a printed report that I've given.

Mr. David Wilks: Thank you very much.

The Chair: Mr. Young.

Mr. Terence Young: Thank you, Chair.

Dr. Landau, I just went on my BlackBerry to try to see what the total sales of OxyContin, oxycodone, would be.

Now, tell me if this is correct, but it looks like in 2010 it would be about $2.5 billion.

● (1025)

Dr. Craig Landau: In Canada?

Mr. Terence Young: Worldwide.

Dr. Craig Landau: It could be.

Mr. Terence Young: As well, in 2011 it was $2.6 billion.

So if you taper that down to when the drug first came on the market in the mid-nineties, it looks like the total sales could be over $20 billion for OxyContin.

Does that make sense?

Dr. Craig Landau: It's possible, sure.

Mr. Terence Young: That's a huge amount of money, so I wanted to get that on the record.

As well, I'm concerned when I hear people from the pharmaceutical industry talk about jobs when we're talking about addictive drugs and patient safety. I don't think one has anything to do with the other. You can't equate them.

I don't know anyone outside the pharmaceutical industry who, when you say, “Help us save lives, help us reduce harm, make sure your drugs only get to patients when they're safe”, starts talking about jobs.

You say that Purdue Pharma has 400 employees in Canada, which is good. But it's Purdue Pharma's aggressive and illegal marketing, we've heard today, with oxycodone and OxyContin that has caused 500 deaths and thousands of addictions.

Mr. James Lunney: That was per year.

Mr. Terence Young: Yes, 500 deaths per year.

Is that the deal, that we now put human life and business—sales—on the same continuum; that when we're talking about human life and human safety, we start talking about jobs and money?

Dr. Craig Landau: May I answer the question?

Mr. Terence Young: Please do.

Dr. Craig Landau: It was certainly not my intention to discount the lives that have been affected by the abuse and misuse of OxyContin. I'm a physician, okay? I just happen to run a pharmaceutical company that produces OxyContin and now markets a product intended to mitigate some of its known risks. We're trying to do the right thing in bringing technology to bear as one component of a risk mitigation strategy that's far more involved for this very difficult problem.

The purpose of mentioning 400 jobs across Canada was simply to acknowledge the fact that I have a commercial affiliation. I'm associated with a company that is a for-profit company. That was my only intention.

The Chair: Thank you very much, Mr. Young.

Mr. Terence Young: Do I have more time?

The Chair: No, sorry.

Mr. Terence Young: Okay. Thank you.

The Chair: We're back now to Ms. Davies, for five minutes, please.

Ms. Libby Davies: Thank you very much.

Clearly there is a huge issue in this country as well as in the U.S. about prescription misuse. Clearly the pharmaceutical industry bears responsibility for misleading information, being too close to the medical profession, everything that we've heard today. But I find it interesting that the elephant in the room is why we don't have government oversight of that. I'm curious that we haven't really heard that from any Conservative member.

Dr. Landau, I'd like to ask you, when you responded to my colleague about what you did in the U.S. with the FDA for that period of time, what happened in Canada? Was there a similar intervention or program or discussion with Health Canada? What happened here in this country?

Dr. Craig Landau: I can't speak to specifics regarding history here in Canada or with Health Canada and the Purdue company.

I can say that there has been a dialogue, and it's ongoing, concerning abuse deterrence, abuse, as well as patient-safety-related outcomes. I myself have engaged in multiple discussions with folks who were concerned and interested in understanding the data we've been able to produce in the United States, and of course the determination FDA made in April of 2013 that the new formulation OxyNEO here in Canada has features that they find helpful from a public health perspective.

I'm encouraged, frankly, by Minister Ambrose's acknowledgement that she intends to re-examine the issue, again as one potential part of a multi-part solution.

If I may, I just want to add one other point.

Ms. Libby Davies: No, I have one other question for you. Has Health Canada contacted you at all about your monographs? Do they review them? When you say that you've had discussions, what are those discussions and who approached whom?

● (1030)

Dr. Craig Landau: Product monographs are data driven. They are drafted by pharmaceutical companies like Purdue and others. They are reviewed and scrutinized internally before they are sent to the regulator and of course at the regulator, Health Canada included. It is a mutual agreement that the product is adequately and appropriately represented by all of the language in a product monograph.

Product monographs, when they are produced, are supposed to represent the state of knowledge and the current understanding of both the product and the discipline that exists at that time. That was, to my knowledge, the case with both OxyNEO, when it was introduced in 2012 here in Canada, and with OxyContin, when it was introduced in 1996 here in the same way.

Ms. Libby Davies: It certainly appears the scrutiny was not very close because we've just heard in the Canadian context what some of the problems were in terms of the lower abuse claims that were made, which were false.

Would you agree that there needs to be some sort of independent oversight by the federal government in terms of the claims that are being put forward? Do you also agree that there needs to be a separation between your industry and what is communicated to doctors in terms of marketing?

Dr. Craig Landau: Simply stated, yes and yes.

On the first suggestion, I don't know precisely how things happen here within Health Canada, but in the United States, for certain, external expertise is often sought, because it is impractical to house the requisite expertise within the building.

On the subject of the pharmaceutical industry's influence of medical practice and understanding and misrepresentation of facts, I agree with Dr. Persaud on the point that there needs to be separation. We're not interested as a business—maybe I can speak for the industry—in misrepresenting facts. We're interested in producing high-quality data that's acknowledged by experts, internal and external to Health Canada, and communicating them appropriately and not influencing unduly through continuing education or other means to drive prescriptions. That's not good business because it's not good medicine.

The Chair: You are pretty well done. You have 15 seconds.

Okay, Mr. Lizon, you have five minutes.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Thank you very much, Mr. Chair.

Thank you to all the witnesses for being here this morning.

I have a question that I keep repeating at almost every meeting.

Dr. Kahan, in your presentation you mentioned how in the 1990s there was a change—an explosion in prescribing OxyContin and the aggressive marketing, etc. Other witnesses also brought this up earlier, that in the 1980s and later, doctors started prescribing opioids for non-cancer treatments and the practice eventually spread to the degree that we have a crisis here.

I'm trying to understand one thing. When they put OxyContin on the market in 1995, it wasn't really a new invention. We've known about opioids for over 200 years. If I have the dates correct, morphine came onto the market in 1804 and was distributed in 1817. Merck sold it commercially in 1827.

So we have 200 years of a history of opioids, and we know very well—and I guess medical practitioners know very well—that they are highly addictive. So how is it possible that an aggressive advertising campaign by a pharmaceutical company did not raise any red flags with medical professionals, with the regulating body, or with anyone else?

I'm trying to understand, so I will give you the floor.

Dr. Meldon Kahan: That's an excellent question.

Purdue conducted focus groups with family doctors throughout the United States, and they found that the concern about addiction was a major barrier, so they tailored their advertisement and marketing towards that. They said controlled-release opiates are not as addicting as immediate-release. This was based on, I would say, a misinterpretation of the studies. Controlled-release opiates are, in fact, way more addicting than immediate-release opiates when they are contained in extremely high doses.

They also said—they made this false distinction between pain patients and addicted patients—that pain patients don't get addicted. In other words, it's all the problem of these dishonest addicts who flock to the doctors and lie to them to get the prescriptions. That's completely false. The patients who get addicted are patients who have legitimate pain problems and who are exposed to it.

You made a very good point. It was amazing how the medical profession rolled over. They rolled over like teenage boys confronted with smoking-cigarette ads. Medical researchers, educators, and everyone else was lecturing family doctors and saying, “you're opiophobic if you're concerned about prescribing controlled-release opiates”.

There was no critical thinking, or there was a very major absence of critical thinking, and in fact, people who were speaking out at public meetings and in writing were criticized by those who said, "You don't want to treat pain. You lack compassion."

So I think it is going to be one of the most tragic and scandalous episodes in medical history, that we as a profession were taken in by this kind of marketing campaign.

● (1035)

The Chair: Dr. Persaud, Mr. Lizon wondered if you'd like to make a comment.

Dr. Navindra Persaud: I would. Thank you for the opportunity.

I think the short answer is billions of dollars in marketing. That is how the fact that opioids and other medications are addictive was overlooked through all of this. They are overlooked by physicians and overlooked by regulators, because the people marketing the medications know what they're doing when they approach regulators and they know what they're doing when they approach physicians, and they have billions of dollars behind them to change people's minds.

If you want another illustration of how it happens, I think you can refer back to some of the comments made in this committee today by the president of Purdue, who's made similar comments about the new formulation of oxycodone that they are marketing today.

The Chair: Thank you very much.

The last round is to Mr. Scarpaleggia, please.

Mr. Francis Scarpaleggia: Thank you, Chair.

Ms. Strang, you were mentioning initially that you thought more data should be collected and shared nationally. Was that you who said that you hoped—

Ms. Lorinda Strang: Yes, I did.

Mr. Francis Scarpaleggia: Could you give us a few examples of the kinds of data that you think should be collected and shared nationally?

Ms. Lorinda Strang: Yes. I have submitted a document and some graphs.

Mr. Francis Scarpaleggia: What kinds of information would be useful to be collected?

Ms. Lorinda Strang: I'm having a hard time hearing.

Mr. Francis Scarpaleggia: I'm sorry. Just very briefly, what kind of data should we be collecting and why? Maybe give three examples of that.

Ms. Lorinda Strang: You should be collecting the current drug trends, the rates of clients that are coming in that are....

We list three drugs of concern. We're going to up it to six. Currently, we can tell you how many of our clients coming in are listing OxyContin as their number one drug of concern. Going forward, we've seen a huge increase in other medications as well. The whole prescription epidemic right now is across the board and we can tell you what drugs our clients are coming in on. Alcohol is still the number one, but it's closely followed by prescription medications or in combination with prescription medications.

I can also give you testimonials from the addicts who are going through withdrawal who will tell you things like: "I got started on OxyContin from a shoulder surgery. The pain of the surgery is much less than the withdrawal. If I could go back and now knowing what I know, I would have sucked up the pain"; or "My name is Eddie, I'm 21 and OxyContin almost made me end my life".

They should have those warnings like on the cigarette ads so we can provide information from marketing.

The statistics we can give you are factual: who's coming in, what drugs of abuse are current.

● (1040)

Mr. Francis Scarpaleggia: Thank you.

Just to end, I would like to ask all four on the teleconference how they would like to see the $45 million that was put aside in the recent budget spent. Where would you spend that money starting, say, with yourself, Ms. Strang?

Ms. Lorinda Strang: I would spend a lot of it on a marketing campaign and I think the Government of Canada right now has started a marketing campaign and it's good—there are commercials. But I think reversing this trend in prescription medications by awareness campaigns....

Mr. Francis Scarpaleggia: Dr. Durnin.

Dr. Maire Durnin: I'd like to see universal funding for opiate-agonist therapy and I'll draw to your attention to the analogy of HIV anti-retroviral therapy in B.C. and the lowered incidences of HIV from good care and open access to medications. I would also like to see industry incentives for people to take back-to-work opportunities that allow them to engage in recovery activities simultaneously.

A lot of my patients end up in low-paying jobs and have to daily walk the line between deciding to come and see me or engage in the other things they need to do for their recovery versus losing their jobs. There needs to be retraining and graduated return-to-work programs that are funded by incentives such as you have available to you.

Mr. Francis Scarpaleggia: Thank you.

Dr. Kahan.

Dr. Meldon Kahan: I'd like to see, similar to what Dr. Durnin said, that opiate substitution therapy—methadone and buprenorphine, as well as naloxone the important opiate overdose prevention tool—be available to all Canadians, including those in first nation communities and in remote communities that right now don't have access to any of those medications.

I'd also like to see an intense campaign similar to Purdue's campaign, but this time focusing on improving physicians' prescribing of opiates and their recognition of opiate addiction in ways to prevent it.

Mr. Francis Scarpaleggia: Finally, Dr. Persaud....

Dr. Navindra Persaud: Thank you.

I'd like to see the resources put towards stronger regulation of marketing and more effective monitoring of harms of prescription drug abuse, and also investigation of previous mismarketing and previous harms that could actually generate revenue for future investigations and future regulation.

The Chair: You're right on time.

We just have a couple of minutes to go. We were going to go in camera, but I think for the sake of time I'll just say it right now.

On February 25 I think the best thing for our committee to do is to have a planning meeting, a working meeting to discuss our next study. We can have a fruitful discussion there.

On February 27 it's quite likely our committee won't sit. In regard to witnesses and having to have them in by the end of this week, I think we can allow some latitude. You're not quite up against the wall there, but certainly over the break next week, think about who you may or may not want to have as witnesses.

Mr. Young, did you have something that you'd like to add here?

Mr. Terence Young: Chair, I just thought the witnesses might like to hear...because of Ms. Davies' comment about the questions the government members were asking.

The government has tabled Vanessa's Law in Parliament in December. Vanessa's Law is very powerful legislation to deal with a whole range of the issues we've talked about today, item by—

Ms. Libby Davies: On a point of order, we're not going to debate the bill here. If you want to, I can tell you that bill doesn't go nearly far enough in terms of addressing drug safety.

We'll have that debate when we get to committee and I'm sure it will be great.

Mr. Terence Young: I wasn't proposing debating the bill, but you were admonishing the government members on the types of questions they asked, which was not appropriate.

Ms. Libby Davies: Yes, but there was an oversight—

The Chair: Thank you.

I want to thank all the witnesses for providing their insight.

This study, I think, is one of the reasons we get into public life, because it is very important to the public and to society. We each may have a different way of getting there, but it's very important to look at an issue such as this.

Thank you, again, and thank you for your honest comments.

Have a safe weekend.

The meeting is adjourned.