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Chair

Mr. Ben Lobb

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● (0845)

[*English*]

The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)): Good morning, ladies and gentlemen. We're continuing our study on Bill C-17. We have a number of witnesses today, so we might as well get right at it.

First of off, we'll start with our guest who's on teleconference this morning.

Ms. Graham, can you hear us okay?

Professor Janice E. Graham (Professor of Pediatrics, Faculty of Medicine, Dalhousie University, As an Individual): Yes, I can.

Can you hear me?

The Chair: We can hear you loud and clear.

We're going to have you go first. We'll have four or five presentations—you'll be first—and then after the conclusion, we'll be open for questions. So can you stay on the line, if that's okay?

You have around 10 minutes for your presentation. Go ahead, if you like.

Prof. Janice E. Graham: Thank you very much for this opportunity to contribute to your study of Bill C-17

I'm going to focus today on why I think amendments to the bill are needed to address openness and transparency of clinical trials data and the decisions surrounding the approval of drugs by Health Canada.

I became interested in the transparency of safety and efficacy data almost 20 years ago while working as a research fellow on a phase four clinical trial. The manufacturer who sponsored our study selected the positive results from our database, ignoring the not-so-positive cases in order to argue for inclusion of that drug into the provincial formulary. I was appalled at the manipulation and wondered how mediocre drugs get approved in the first place given their cost to our health care system.

Between 2001 and 2006, I conducted extensive anthropological research at Health Canada's regulatory authorities. I was observing drug evaluations, regulatory activities, and decision-making. Also, I participated in progressive licensing consultations with Health Canada and I chaired their expert advisory committee on the special access program.

Concerns and recommendations that our committee made in 2008 about the role and fit of regulatory modernization were never made public and several apply to the recommendations for Bill C-17.

In 2004, Health Canada received the Code of Silence award from the Canadian Association of Journalists as the most secretive government department for denying access to drug databases that could harm or kill Canadians. The CAJ charged that commercial interests trumped Canadians' health. Regulatory capture, a term that gets used by all sides to accuse a regulatory authority of favouring the interests of one stakeholder over another, can happen in any sector. It's non-partisan.

The ability of Health Canada's regulatory evaluators and independent reviewers to do their job is challenged when assessing partial and incomplete data. I do not wish to criticize the dedicated work carried on by Health Canada's regulators. They work under considerable structural and financial constraints. Hiring just a few more evaluators in 2004 and 2005—while I was doing my research there—enabled the directorates to move out of years of backlog.

Improvements in recent years have made Health Canada's activities and reports more readily accessible. But these still remain weak instruments, lacking important details about the research design and methodologies, data, critical appraisal, and the assessment that would ensure unbiased results and analyses. While Health Canada's reviewers use many mechanisms to arrive at their decisions, including bilateral consultations with the sponsor and ongoing clarification of their questioning during reviews, I suggested there remains an essential role for independent appraisal that requires open access to the clinical trial data and to Health Canada's decision-making.

As a case in point, Health Canada's assessment of the stem cell therapy Prochymal left more questions than answers. In 2012, Canada became the first country to conditionally approve Prochymal for the treatment of acute graft-versus-host disease in children. Approval was based on very encouraging data showing clinically meaningful responses provided by the sponsor. The U.S. FDA wasn't convinced though and denied approval of that drug. The manufacturer, Osiris, planned to use Prochymal for the treatment of many other diseases, opening the door to multiple off-licence indications.

The fact that the panel recommended a warning for the product monograph to say, “The long term effects of Prochymal® in growing children are unknown“ would, I hope, have alerted the marketed health products directorate to a ticking time bomb.

Based on limited and unpublished clinical trial data, Canada's decision to approve Prochymal was lauded as a huge achievement by the financial and drug development communities. Canada was seen to be signaling a shift, that they were open to industry for faster access, more than for the safe drugs that Canadians need as promised in the 2003 throne speech.

Health Canada's summary basis of decision-making for Prochymal presented a confused picture of the criteria and proceedings that allowed its approval. Data from two unpublished studies were used to arrive at the decision, and one didn't even meet statistical significance for the critical end point. I quote from the summary basis of decision-making:

> To date, only preliminary evidence exists to indicate a potential therapeutic value for Prochymal; however, so far, Prochymal has not exhibited worrisome toxicity and has shown a relatively benign safety profile.

I submit to you that so does a placebo and the evidence was that this trial was based on only 28 days of clinical research.

● (0850)

HPFB's own consultations say that the summary basis of decision documents do “not contain enough detailed information about clinical trials including study participants, results and harms to truly allow consumers and health care providers to make informed choices.”

In a business article titled “How to Tell When a Drug Company Fibs About Clinical Trial Results”, Adam Feuerstein wrote:

> Osiris Therapeutics “disappeared” important data when the company announced results...from a mid-stage study of its stem cell therapy Prochymal in heart attack patients.

Regulation works well when it takes nothing for granted and has multiple, iterative mechanisms to control for potential gaps. The good regulator wears both a belt and suspenders. I don't think any of us wants Canadian regulators caught with their pants down. I cannot afford a ticking time bomb—none of us can. Bill C-17 does not go far enough in ensuring independent, systematic review of all clinical trial data. Steps to ensure access to clarifications and consultations between industry sponsors and regulators, and the details in rationale for drug approval, approval with conditions, refusal, and suspended or recalled drugs, are not included in the present draft of Bill C-17. Neither is budgetary commitment to provide the resources for the enhanced regulatory activities that modernization will need to meet obligations to Canadians for the safety and efficacy of therapeutic health products. Without budgetary commitment to carry out these extra activities, provisions in the act will be futile.

Regulatory modernization has swept across nations. It's intended to keep pace with our political neighbours in terms of policy, economy, and science and technology, but it can also be an opportunity for clinical trialists and regulators to adopt new, more robust methodologies. While Bill C-17 will enhance the recall powers of the health minister, it puts no emphasis on enhancing the capacity and capability of Health Canada with the precautionary buffer of independent review and access to decision-making.

Instead, regulatory modernization has pushed for post-market surveillance and follow-up for conditionally approved drugs, many of which should be stopped at the gate. With quicker access to these drugs, Canadians risk becoming phase four clinical trial guinea pigs who are not protected by the careful controls in traditional phase one, two, and three clinical trials.

Without the benefits of independent, open and transparent access to clinical trial results, the authorization and approval of the use of medications remain an ethically unjustifiable black box. Bill C-17 will serve all Canadians better if it can address this gap. As the journal *Nature* points out:

> Greater openness about clinical-trial data should help to speed up drug development, provide independent assessments of drug safety and efficacy and increase trust in industry science.

It's a win-win for us all.

Thank you.

The Chair: Thank you very much.

Next up by video conference, we have...is it Joel Lexchin?

Dr. Joel Lexchin (Professor, School of Health Policy and Management, York University, As an Individual): It's Lexchin, like you're going to have in two days.

The Chair: Like an election.... Well, all right. Welcome, Mr. Lexchin.

You have 10 minutes, so go ahead, sir.

Dr. Joel Lexchin: I want to thank the standing committee for the opportunity to appear today.

I teach health policy at York University and work as an emergency physician at the University Health Network in Toronto. I've been analyzing, talking about, and writing about pharmaceutical policy for over 30 years, and I'm the author or co-author of about 140 peer-reviewed articles on these topics.

My testimony is going to focus on three issues: first, the need to ensure that any post-market studies are carried out in a timely manner; second, the problems with clinical trials conducted by companies making the products being tested; and finally, the need to improve on the amount of information that Health Canada discloses after it has approved a new drug.

In discussing the first issue, I'll examine the situation regarding the notice of compliance with conditions policy. For the second, I will use the results of a recent systematic review that looks at the results and conclusions of trials funded by drug companies, and those trials that receive funding from other sources. And for the third issue, I'll draw on a study that I and a graduate student recently published, that looked at the quantity and quality of information that's disclosed in the summary basis of decision documents that Health Canada releases after it approves a new drug.

With regard to the notice of compliance with conditions, this is a policy that was adopted back in 1998, and the goal was—and here's a quote from Health Canada—to provide patients suffering from "serious, life-threatening or severely debilitating diseases or conditions" with earlier access to promising new drugs. This is where surrogate markers have suggested that these products offer "effective treatment, prevention, or diagnosis of a disease or condition for which no drug is presently marketed in Canada", or significantly improve efficacy or significantly diminish risk over existing therapies.

One example of a surrogate marker would be that a drug shrinks the size of a cancer tumour. In return for getting a notice of compliance with conditions, companies have to commit, in writing, to undertake confirmatory studies—that is, studies that definitively establish efficacy—and then submit these results to the therapeutic products directorate at Health Canada. If these post-marketing trials do not provide sufficient evidence of clinical benefit, the notice of compliance with conditions could be revoked and products removed from the market. Health Canada will also issue a notice of compliance with conditions for a new indication for an existing product.

Since this policy was adopted in 1998, Health Canada has issued a total of 60 notices of compliance with conditions for either new active substances—these are molecules that have never before been marketed in Canada—or new indications for existing drugs. Out of these 60, seven were either revoked, suspended, not fulfilled, or removed, which leaves 53. Out of those 53, 28 have been fulfilled and 25 have yet to be fulfilled.

A table that I've provided in this brief shows that it took six years for four or more of these 28 to be fulfilled, and of the 25 that have yet to be fulfilled, 15 have been on the market for more than six years. Some have been on the market for as long as 12 years, which means that these drugs are being prescribed by doctors, being taken by patients, and nobody really knows either how well they work, or if they work at all.

Health Canada provides no information that's publicly available as to the status of the clinical trials that are supposed to be undertaken to fulfill the conditions for which these products were licensed.

The second topic is trials funded by drug companies. About 80% of all clinical trials are funded by pharmaceutical companies.

● (0855)

I recently participated in a Cochrane Collaboration review that looked at the results and conclusions of trials funded by drug companies and those that received their funding from other sources. Just as a brief bit of background, the Cochrane Collaboration is an independent, non-profit, non-governmental organization consisting of about 31,000 volunteers in more than 20 countries. It was formed to organize medical research information in a systematic way to facilitate the choices that health professionals, patients, policy-makers, and others face in health interventions according to the principles of evidence-based medicine.

Our review, which was published two years ago, found that studies that were sponsored by drug and device companies more often had favourable results and conclusions than those that were sponsored by any other source. The findings were consistent across a wide range of diseases and treatments. Specifically, we found that if a study was sponsored by a company, the results were 2.15 times more likely to be positive and the conclusions 2.67 times more likely to be positive than if any other source—charities, hospitals, universities, CIHR—had funded the trials. This indicates that the mere fact that drug companies are sponsors of the trials creates a bias that they're likely to be positive. If the committee wants a copy of this review, I'd be happy to provide an electronic copy.

Finally, with regard to the summary basis of decision documents, this is an initiative that Health Canada started as of January 1, 2005. This is a document that's issued after a new drug or medical device is approved, and it explains the scientific and benefit-risk information that was considered prior to approving the product. Of particular interest to people like me, who are health care professionals, is the section of the summary basis of decision document that contains a description of the pre-market clinical trials that were examined by Health Canada and a summary of the final risk-benefit assessment of the product. Health Canada's position is that as a result of the summary basis of decision documents, Canadian health care professionals and patients will have more information at their disposal to support informed treatment choices.

Recently a graduate student of mine and I examined all 161 summary basis of decision documents that looked at a total of 456 clinical trials that Health Canada had examined between January 1, 2005, and the end of April 2012. We looked particularly at the information that was disclosed about the safety and efficacy of the drugs. We were interested in information about the characteristics of the patients who participated in the trials and about the risks and benefits of the drugs.

For the characteristics of the patients, we looked at information about age, sex, whether the patients were in hospital or were outpatients, and how the patients were chosen for inclusion in the trial.

For the risks and benefits of the drugs, we looked at information about how long the study ran, the statistical significance of the results, whether the drug was compared to a placebo or another drug, what percentage of patients withdrew from the trial, and if there was any difference between the withdrawal rates for people who were taking the new drug and the withdrawal rates for people who were taking either the placebo or the comparator drug.

Here are some of the results we found. The number of summary basis of decision documents that fully reported on the sex of the patient was 32 out of 161. The number of documents that fully reported on the age of the patients was 53 out of 161.

● (0900)

The number of documents that reported on how long the trials ran was 90 out of 161. The number of documents that reported on how many people withdrew from the trials was four out of 157. Four of the documents couldn't be analyzed for this issue. The number of documents that fully reported on differences between withdrawal rates for people taking the new drug and people who were taking either the placebo or the comparator drug was one out of 154.

Our conclusions were:

> Overall, clinical trial information in SBDs is presented in a haphazard manner, with no apparent method to its presentation....at least one-third of the potential information about patient trial characteristics and the benefits and risks of tested treatments is missing.

I would be happy to provide an electronic copy of this study to the committee.

Based on the foregoing information, I have two recommendations for changes in Bill C-17.

First, if Health Canada requires post-market trials for drugs, then it has to report on a regular basis, probably annually, on the status of those trials. For instance, are they delayed, and if so why? When are they expected to start? Are they in progress, and when are they expected to be completed? If they are completed, what were the results?

Second, Health Canada should ensure that all of the results of clinical trials dealing with the safety and efficacy of a new drug are made publicly available within one year of completion of the trial, after they have redacted any information that might identify any individual patients.

Finally, I think that Health Canada needs to institute a mechanism of separating the funding of any post-market study from the conduct of the trial. What I'm suggesting is that the company that has committed to undertake the trial give the money to do that trial to CIHR. CIHR would then select the researchers, who would design and undertake the trial; those researchers would analyze the results of the trial independent of the company, and the results of the trials would be made public.

Thank you very much for listening to me.

● (0905)

The Chair: Thank you very much, Doctor.

Next up we have as an individual Elaine Gibson.

Go ahead, for 10 minutes.

Professor Elaine Gibson (Associate Professor, Health Law Institute, Dalhousie Schulich School of Law, As an Individual): Thank you. I apologize in advance. We were originally scheduled to be here until 9:45 and I'll have to leave shortly before 10:00, so I won't be here for the full two hours.

It's an embarrassment to our nation that Health Canada does not at present have the power to recall a pharmaceutical product from our market. I urge the committee members to rectify this omission by ensuring the passage of Bill C-17. You will thereby play an important role in helping to protect the safety of Canadians.

That said, there are a number of ways in which Bill C-17 can and should be enhanced. Others on this panel are speaking to the critical matter of transparency. I'm not going to address this. I'm going to outline three other measures that I urge you to embrace. These measures are simple, straightforward, and I hope, easy to comprehend. I'm happy to take questions after.

I'm even going to give you the suggested wording for the amendments that I propose. Despite how basic they are, these measures have the potential to dramatically improve patient safety, which is, as you know, the intended aim of the bill before you.

Here they are. First, expand the application of Bill C-17 to ensure that it applies to all holders of therapeutic product authorizations. Second, incorporate a greater range of adverse events. Third, exempt Health Canada from liability for measures taken in good faith.

I'll go through these one-by-one.

First, expanding the application of Bill C-17. The language at present generally refers to holders of therapeutic product authorizations. However, the specific provision on ability to recall refers only to sellers of products. The production and distribution of pharmaceuticals is complex and may involve several companies. Not all holders may be sellers.

For example, a company holding the authorization may license product sales to a different company and therefore not fall within the definition of seller. The recall provisions in the bill should be amended to capture all entities in the production chain and should specifically refer to the holders of therapeutic product authorizations.

Second, incorporate a greater range of adverse events. The language of the bill at present refers to injury and to harm. You may recall the incident last year regarding packaging of the birth control medication Alysena. Health Canada initially took the view that the problem with the packaging, potentially leading to numerous pregnancies in Canada and having resulted now in multiple claims of unwanted pregnancy and lawsuits, did not constitute a serious adverse health consequence.

They eventually accepted that if a particular woman should not get pregnant specifically for medical reasons, this would constitute such an adverse consequence, but not simply if she was opting not to get pregnant; i.e. taking the birth control pill for non-medical reasons.

In other words, pregnancy was and is, I assume in the interpretation of Health Canada, a lifestyle choice and not a serious adverse event.

The wording of Bill C-17 should be altered to incorporate language that envelopes situations of product mislabelling or mispackaging. Suggested wording is as follows, “For greater clarity, an adverse drug reaction includes but is not limited to circumstances in which the therapeutic product does not have its intended effect due to mislabelling or mispackaging of the product”.

An adverse drug reaction includes circumstances in which the drug does not have its intended effect due to mislabelling or mispackaging of the product.

Third, exempt Health Canada from liability for measures taken in good faith. Last and perhaps most importantly, the Minister of Health or her designate need to be able to exercise the powers outlined in Bill C-17 with impunity, provided that they act in good faith. Tort liability is in my view a marvellous mechanism for accountability and I would not usually be arguing for immunity on the part of government from its actions; however, consider this.

● (0910)

Pharmaceutical companies are among the most powerful corporations in the world. The total revenue of the Government of Canada for 2012-13 was $257 billion. The total revenue of the top 10 pharmaceutical corporations combined was over $400 billion in 2013. The total revenue of the top 50 pharmaceutical corporations was $610 billion in 2012. The incentive on the part of pharmaceutical corporations to commence lawsuits is high. In recent years they have engaged in illegal activities, and faced and absorbed fines for these illegal activities in the billions of dollars with barely a blink in their ability to continue functioning. It's not exactly David and Goliath, the Government of Canada versus pharmaceutical corporations, but you get the idea. To restate the basic facts I just outlined, Canada's total government revenue was $257 billion. The top 10 pharmaceutical companies' is over $400 billion.

I'm concerned that Health Canada will be impeded in its ability to execute the functions outlined in Bill C-17 for fear of lawsuits that could place a serious dent in our economy. Take the example of a precautionary recall of a product from the market in light of concerns followed by evidence accumulated by the corporation that the recall proved not to be necessary in the end. One can well imagine a lawsuit by the seller for sales lost during that period of recall. A primary means to ensure that Health Canada can vigorously pursue its mandate to protect Canadians is to amend Bill C-17 to incorporate a clear exemption from liability.

What would such an exemption look like? Here's some draft wording for example. The clerks have copies of this and you can get it after.

> The government is not liable in respect of any loss or damage caused or resulting, directly or indirectly, by or from,
>
> (a) the enactment of (specified sections of) this Act or a regulation or standard made under these sections of this Act, or
>
> (b) anything done or omitted in the exercise or performance or purported exercise or performance of a power or duty conferred under this Act or regulations unless the person who brings the action proves that the person exercising or performing or purporting to exercise or perform the power or duty was not acting in good faith.

What is good faith? It's acting not with maleficent or evil aim, in other words, acting positively in a moral sense. Then if this measure is enacted, the government is immune from lawsuits for its actions in this regard.

In conclusion I urge you to promote the passage of Bill C-17 along with the specific enhancements that I'm recommending. The stated aim of the bill is to protect Canadians from unsafe drugs. These measures will ensure that the bill, once it becomes law, will live up to its lofty name. Members of this committee are uniquely poised to play a positive role in protecting Canadians and I encourage you to do so.

● (0915)

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

Next up, we have Mr. Herder.

Go ahead, sir, for 10 minutes.

Professor Matthew Herder (Assistant Professor, Faculties of Medicine and Law, Health Law Institute, Dalhousie University, As an Individual): Thank you, Chair.

Thank you for the privilege of appearing before you today. l'm a legal scholar with expertise in intellectual property law. Given time constraints, l'm going to focus solely on the issue of transparency, which Bill C-17 does not address. l have two themes, each with a few specific points that l want to touch upon. I'll conclude by reading five key provisions that l think should be added to the bill.

My first theme is to make evidence and regulatory work transparent.

First, amend Bill C-17 to make registration of all clinical trials, from phase one to phase four, as well as other investigational studies and the reporting of all such study results, mandatory for all new drugs and new indications for existing drugs that are submitted for regulatory approval, whether those submissions are successful or not.

Second, empower the Minister of Health to disclose clinical study reports. Access to clinical study reports and the data they contain can be critical to understanding the quality of the evidence behind a given drug.

A study published just last week in the *British Medical Journal* comparing clinical study reports with published information regarding duloxetine, a commonly prescribed treatment for major depressive disorder in Canada, concluded, “Clinical study reports contained extensive data on major harms that were unavailable” from other sources.

The optimal procedures for sharing clinical study reports are the subject of live debate. For that reason, defining the procedures by which clinical study reports should be made available by way of regulations is appropriate. But vesting the minister with the authority to make them available is critical.

Third, require the minister to publicly report all decisions, including product approvals, refusals, suspensions, and recalls, and the reasons behind those decisions. Patients, physicians, researchers, indeed drug manufacturers and other regulators would benefit from knowing how the regulator is interpreting the evidence. In time, this will improve the quality of the regulator's decision-making and Canadians' confidence in it.

Fourth, attach real penalties to non-compliance with transparency requirements. Despite clear penalties backed by the force of law, in the United States compliance has been less than adequate. According to one study, 78% of trials registered on ClinicalTrials.gov failed to provide results within the statutory one-year timeframe.

I therefore suggest a modified enforcement strategy. As is done in the U.S., Bill C-17 should make failure to comply with registration and results reporting subject to monetary fines. However, Bill C-17 should also tie results reporting to market approval.

Bill C-17 already includes an amendment to the Food and Drugs Act that would require manufacturers to comply with any terms or conditions attached to the market approval. This power should not be used only on occasion. Rather, that new power should be used in every single drug approval where results reporting is, at the time of market authorization, still incomplete. Where the regulator rejects a drug or a new indication for an existing drug, and the results reporting requirement has not been fulfilled—it has to be within six months—manufacturers should incur an additional monetary fine.

The second theme is to make it absolutely clear that transparency trumps commercial claims.

Here's my first point. Subclause 6(6) of Bill C-17 proposes a modification to subsection 30(3) of the current Food and Drugs Act. The proposed change opens the door to limiting the powers contained in the act in order to implement trade agreement articles relating to intellectual property. This proposed amendment should be deleted from the bill. The federal government's responsibility to protect the welfare of Canadians should not be reduced by trade objectives.

On my second point, and this is my last point, claims by manufacturers that certain information is proprietary—that is, confidential business information or trade secrets—has long been the central barrier to transparency. However, consistent with its international obligations, Canada's food and drug regulations already protect data against unfair commercial use, providing eight years of data exclusivity to innovative drugs on top of any available patent protection. Nevertheless, it is received wisdom within Health Canada that information about drug safety and effectiveness cannot be disclosed. Consequently, Bill C-17 must make it plain that the regulator has the power to disclose that information.

● (0920)

People have given up their bodies and taken on serious, even life-threatening, risks to help generate that information. It is not for the companies to own in secret, and the regulator has to be free to disclose it.

To conclude, here are five provisions that should be added to Bill C-17, in light of the foregoing.

First, all clinical trials and other investigational studies involving a therapeutic product shall be registered on a publicly accessible, searchable database before participant recruitment begins, in accordance with the regulations. As well, the minister shall not issue a market authorization in respect of a therapeutic product unless any clinical trials and other investigational studies involving said therapeutic product were registered in accordance with this provision, whether or not those trials and other investigational studies were carried out in Canada.

Second, all clinical trials and other investigational studies involving a therapeutic product shall report the results thereof on a publicly accessible, searchable database within one year of the completion of the trial or study, in accordance with the regulations. As well, where the results of one or more completed trials or investigational studies associated with the therapeutic product have not been reported in accordance with this provision prior to market authorization, the minister shall require as a condition of market authorization that such results be reported in accordance with this provision within six months of the date of market authorization. Finally, in the event that a therapeutic product is not granted a market authorization by the minister, the manufacturer shall report the results of all clinical trials and investigational studies in accordance with this provision within six months of the date of the minister's decision not to grant market authorization.

Third, the minister may publicly disclose clinical study reports in accordance with the regulations.

Fourth, the minister shall disclose in a publicly accessible, searchable database, information about therapeutic product authorizations, including any terms or conditions associated with a therapeutic product authorization, indication changes, refusals, suspensions, and recalls, and the reasons for each such decision.

Fifth, the minister, in fulfilling the foregoing provisions, shall publicly disclose information regarding the safety and effectiveness of a therapeutic product, including adverse drug reactions, which it receives from manufacturers, health-care institutions, and other persons. As well, information referred to in this provision shall not be used by a manufacturer for unfair commercial purposes as described by the regulations.

Those are the provisions I suggest are essential to add in their entirety to the bill for it to achieve its full promise.

Thank you.

The Chair: Thank you very much.

The final presentation for the morning is from Ms. Hyland. Go ahead. You have 10 minutes.

Ms. Sylvia Hyland (Vice President and Chief Operating Officer, Institute for Safe Medication Practices Canada): Mr. Chair, members of the committee, and staff, thank you for giving me the opportunity to be here on behalf of ISMP Canada.

I would like to state our strong support for Bill C-17,, the protecting Canadians from unsafe drugs act, also known as Vanessa's law.

ISMP Canada is an independent, not-for-profit organization established in 2000 to analyze incidents of preventable harm from medications, to identify system improvements, and to work collaboratively to advance medication safety.

One of the key elements in Bill C-17 is a stronger requirement for reporting by health care institutions of serious adverse drug reactions and medical device incidents that involve drugs. We believe that this will better identify drug-related risks.

Repeated research has shown that harm from medications happens more frequently than practitioners and the public realize. A study in 2008 found that more than one in nine emergency department visits are due to drug-related adverse events, of which 68% were thought to be preventable. The research, along with experience, has shown that in many cases harm can be prevented and patients can be protected, but only if we as health care providers and administrators are aware of the problems.

One of the ways we become aware of the problems is through a robust reporting system. The value of improved reporting will be more information to better evaluate a drug's benefit-to-risk ratio. With adverse event or adverse reaction reporting, anyone can make a report. One report can make a difference and ultimately impact on the way that health care is provided.

Our organization works closely with hospitals, and we know that reporting is taking place on a voluntary basis. There is a growing culture of safety and a growing awareness of the value of reporting. We also know that the reporting of harm from medications is variable. The bill provides impetus to build on existing infrastructure, create more consistency, and adopt standardized approaches so that the quality of data collected can improve.

A readiness for this bill exists. It is our experience that when there is recognized value, additional work on the part of practitioners or organizations will not be a barrier to implementation. There is a level of awareness that, if enacted, this legislation will not only promote reporting but will spark more collaboration at the provincial and national levels.

With this bill we have an opportunity to identify best practices for reporting and for coordinating existing systems to provide adverse drug reaction data to Health Canada. There will be opportunity to link this work through such advancing technologies as the electronic health record and thereby continuously improve data capture on the use and safety of medications.

As well, analysis and interpretation of data will improve. One of the limitations of the current system for voluntary reporting by practitioners in hospitals is that it is not possible to infer or project the probability of specific harms. This can be improved with mandatory reporting. In other words, voluntary reports of severe and unexpected cases of harm from medications help to detect new risks and can provide early warning. However, increasing the number of reports through a mandatory process in hospitals will also help to identify trends and will better support continuous evaluation of a drug's benefit-to-risk balance.

Our organization works closely with consumers and patients, and it is our experience that most consumers and patients are under the impression that mandatory reporting already exists. This bill helps us to live up to their expectations. Ultimately, this bill will help ensure that practitioners, together with patients, have enough information to make an educated decision about drug treatment.

A second key component of the bill is strengthening safety oversight by providing Health Canada with increased authorities.

Health Canada's life-cycle approach to drug safety oversight recognizes the need for continuous evaluation of the use of a drug and its benefit-to-risk balance in the real world experience. The bill empowers Health Canada to require licence holders to conduct assessments, compile information on product use, conduct tests or monitor experience, take preventative measures, and monitor the effectiveness of such measures.

Pharmacovigilance activities are now being viewed more broadly as relating to not only adverse reactions that inform the inherent benefit-to-risk ratio of the drug molecule itself but also the preventable adverse events that inform health care system improvements, practice improvements, and label improvements.

● (0925)

For example, following analysis of medication errors, which by their nature are preventable harms from medication, we have worked with manufacturers and Health Canada to improve package label design, so that critical information is the most prominent information, rather than, for example, emphasis placed on branding or marketing. In this way, we can increase the probability that important information will stand out and also reduce the risk for error.

The authorities provided in the bill will allow greater influence on the unique considerations for the package and its label, the product monograph, the package insert, and the patient information provided. With the evolution of medication safety, we now know much more about designing labels for safety, designing labels and packages with the end user in mind, and utilizing human factors expertise to help ensure optimal representation of information and reduce risk of error.

There is a tension between the safety science and the many efforts to market, brand, and sell a product. The two can be at odds. It is important that Health Canada be positioned to assert safety over marketing, safety over branding, and safety over sales. We need to have Health Canada in a position to demand quick action when the safety of Canadians is at risk.

I acknowledge that there have been pharmacovigilance advances and successful safety initiatives accomplished within the limitations and constraints of the current Food and Drugs Act.

Many manufacturers have moved quickly to improve product problems when compelling information for change has come forward, but not always. By enabling a prompt response to identified risks, such as requiring a label change or to make new safety information available, or ordering a product recall, we believe that the safety of patients is enhanced.

Again, as we work with consumers and patients, we often find that they are under the impression that Health Canada already has the authorities outlined in the bill. The bill helps us live up to their expectations.

In summary, the components of Vanessa's law encourage collaboration and system improvement for reporting of serious adverse drug reactions. The bill aligns Health Canada authority with expected accountability and responsibility.

The bill has undergone extensive study and consultation, and it meets the test of reasonableness. We are grateful for this chance to encourage the standing committee to move forward with Bill C-17.

Thank you again, Mr. Chair, and members of the committee, for this opportunity. I look forward to our discussions and the next steps.

● (0930)

The Chair: Ms. Gibson, you indicated that you have to leave at 20 to, or a quarter to. Is that right?

Prof. Elaine Gibson: I'll probably leave at five to 10:00.

The Chair: I say that, so that if anybody has specific questions for you, they direct them to you before you go. I'm not trying to tell anybody who to ask questions to though.

Ms. Davies, you have seven minutes.

Ms. Libby Davies (Vancouver East, NDP): Thank you very much, Chairperson, and thank you to all of the witnesses for being here today. You're clearly experts in the field and it's much appreciated that you've been so specific today.

I think that there's strong support for this bill from all parties. It's very unfortunate, though, that it's being jammed through at the last minute. We've had something like 45 witnesses who have been asked to appear. Last Thursday, we heard from the government officials. Today, we're hearing from the five of you. We'll hear from some more witnesses on Thursday and then we're into clause-by-clause on Monday. I think what is important is that we get this bill right. We take a good proposition and we try to make it the best that we can make it. You've given us some very specific suggestions. I think it's very unfortunate that we won't get to hear most of the witnesses who want to be heard on this bill.

The bill sat around for six months because the government didn't call it. Now, at the eleventh hour, there's a crisis and it has to be rushed through. I want to get that on the public record because I think it's very disturbing.

In terms of the testimony that you've given I want to clarify a couple of things.

Janice, you made a number of points and you mentioned that the independent appraisal of all clinical trial data was important and that it should be independent.

Joel, you also suggested that the pharmaceutical companies should pay for the independent trials so as to separate the money from whoever does the trial. I want to understand whether the two of you are talking about the same thing or whether you're actually talking about separate things. Could you address that?

Matthew, you made some specific recommendations that were very helpful. One that hasn't received a lot of attention is the issue of deleting—I forget the clause number—the clause that deals with the trade agreements overriding this bill. I'd like you to spell that out a bit more. As I understand it, from what you're saying, if we have transparency in this bill and if it came down to a trade agreement that had privacy over the intellectual property rights with some of these drugs, then the trade agreement would overtake this bill and the transparency wouldn't exist. I want you to clarify what you're saying.

Would any of you care to address whether or not you think this bill should be broadened to include natural health products? We've received a whack of emails from people who think that should be the case. We did talk to the Minister about it and she said that natural health products are considered to be a much lower risk. In terms of what we're dealing with in this bill I think that seems to be a reasonable assumption. I would like to get your take on it because you are experts on drug safety. Do you think, at this point, we should contemplate whether or not natural health products should be included?

I know there are a lot of points. I'd appreciate it if Joel, Matthew, and Elaine would comment.

● (0935)

Dr. Joel Lexchin: I can start with the points about independent evaluation.

First of all, there are my suggestions about who does the trials, who analyzes them, and whether or not these are the trials that would be required. The second point about independent analysis is that, even with all of the best intentions, people make mistakes when they're analyzing trials. Health Canada does. Independent researchers do. I think you need full disclosure, as was said, of the clinical trial reports. Once a drug is on the market, people can go back to that kind of information, look at it, and see whether or not they think that the right decisions were made. Perhaps they could analyze that information in different ways and point out things that weren't apparent to the people who initially did the analysis.

I think these two things are complementary.

Prof. Janice E. Graham: I can speak to this, if I may. Yes, I agree with Joel that they're complementary. In what I presented, I was really focusing on independent appraisal by people not involved at all in the clinical trial and people who weren't necessarily government regulators. At the same time, I would absolutely reinforce and agree with what Joel is suggesting.

I am on the record as saying this for about 10 years. In Canada, everywhere, it would be ideal if industry would give over the money they're spending on trials—which they partially give to academic researchers—and instead give that money to a completely independent source, like perhaps CIHR, who could then determine who could do these trials, so that the clinical researchers are not going cap in hand to industry to conduct the trials for them.

Prof. Matthew Herder: I'll speak to the specific issue, if I may, of that provision on trade agreements.

The current wording of the statute is that it's a power to make regulations in respect of the trade agreements and the opening language of the clause is, “without limiting the powers conferred elsewhere in this act”, or something essentially to that effect, so that you can create regulations to deal with these trade commitments, but they don't undermine or shape the powers that are already in the statute outside of that set of regulations.

Under the proposed amendment, in Bill C-17, the language is, “Without limiting the power conferred” in this section, so that means, by implication, that implementing those trade agreements or commitments around those trade agreements around intellectual property, could shape powers elsewhere in the legislation. That's my interpretation of the effect of that wording. That's very subtle. It does not necessarily shape those powers. It just creates the possibility of doing that in the name of trade and respecting particular articles in NAFTA and the TRIPS agreement around intellectual property.

I hope that clarifies it. The first time I read the bill, I didn't catch it. It's very subtle language, but I think it's important and it opens the door to sort of fettering responsibilities or powers that are in the legislation around recalls, things in the name of patient safety or transparency. It could, in theory, certainly be tempered by virtue of that new wording.

● (0940)

Prof. Elaine Gibson: I will address your last question on natural health products.

The Chair: Can you put it in about 20 seconds? We're way over time.

Prof. Elaine Gibson: No, don't include natural health products.

The Chair: Okay.

Prof. Elaine Gibson: It’s too complicated; that will bog it down. There's no reason they need to be twinned.

The Chair: That's pretty succinct.

Ms. Adams, go ahead.

Ms. Eve Adams (Mississauga—Brampton South, CPC): Thank you very much.

Thank you all for joining us today.

In the recent CMHA article that all of you co-authored, the subject of clinical trials was the main point that I took away, where you suggested that we really needed to improve this legislation regarding clinical trials.

Can you provide a comprehensive overview of what elements you feel are the most important aspects that we amend in this legislation to get that aspect right?

Prof. Matthew Herder: I'm not sure if I quite understand the question. Are you asking with respect to clinical trials as a whole or the information around clinical trials that you thought, by virtue of a commitment to transparency, were asking to be made transparent?

Ms. Eve Adams: Precisely. If we were to develop an amendment that best reflected that and captured that, what would you recommend that it absolutely include?

Prof. Matthew Herder: I might defer to Joel and Janice for some of the particulars, but what I can say that I think is helpful is that there's been a lot of work to define the particular elements. The World Health Organization has sort of done some work that has led to a minimal set of information to be included: the number of patients, those who withdrew from the trial, the different kinds of outcomes they are looking for in the trial, the design of the trials. There are ready-made lists that talk about the key pieces of information to be included under any system of clinical trial registration.

Perhaps Joel and Janice can describe some of the more particular pieces of information.

Dr. Joel Lexchin: First of all, I would say that the clinical study reports would have to be made available. These are comprehensive documents. Sometimes they run into thousands of pages. Not everybody's going to read them, but people who do things like develop guidelines for practitioners, who do systematic reviews, will definitely read these and analyze them.

The other feature we need to make sure comes out, and this is not something that's particularly radical—GlaxoSmithKline has already made a commitment to do this—is that the full reports of all of the trials that have been undertaken will be released to qualified researchers. People will make applications to GlaxoSmithKline. The company is going to set up an independent committee to evaluate those requests to make sure they are legitimate, and if they are legitimate then GlaxoSmithKline will release all of the information. That's the raw data they collected in the conduct of the trials for their drugs.

I think we need two things. One is an unequivocal release of the clinical study reports without any formal requests. Secondly, the companies, on receipt of a valid request from researchers, will release all of the raw data for the clinical trials.

● (0945)

Ms. Eve Adams: That actually speaks to another aspect. At Health Canada, I think there is a concern between balancing private business information and obviously ensuring that patients' safety is paramount. My perspective and I would imagine the perspective of everyone around this table is that consumer safety, patient safety, is just such an important priority that we really need to ensure that's where we put the focus and not as much on protecting private commercial information.

How would you strike the balance? Is this how you would suggest the best balance could be struck?

Dr. Joel Lexchin: Yes, I would. I think as a clinician, somebody who prescribes, patient safety is paramount, and I think that trumps anything else.

Manufacturers have legitimate concerns around things like how they make drugs that need to be protected. There are manufacturing secrets. We should obviously not disclose information where individual patients could be identified, but beyond that, safety trumps commercial secrecy.

Ms. Eve Adams: I would fully concur.

Are there any other suggestions around the table on how we might strike that balance, or what else we ought to be making public?

Prof. Matthew Herder: I guess I would simply echo that—I thought you were asking specifically about registration as a starter—other kinds of information are critical to get out as well. There's such a course of support for transparency right now that if we limit it to clinical trial registration, which has been happening for years and years in other countries, it's really at the risk of being a pyrrhic victory. We need results reporting backed by serious enforcement measures. We need clinical study reports. It's how we make them available, making sure we protect patients privacy, and excluding material or information such as Joel described around manufacturing processes.

But information derived from patients participating in studies about the safety and effectiveness of a drug has to be made available, and that's going to be most richly available in the clinical study reports.

Lastly we need the information about how Health Canada is interpreting that evidence. We're talking about probabilities and lots of uncertainty. Regulators come to different conclusions about the same drug for the same indication. There's a lot of complexity here, and regulators can learn from each other and learn in dialogue with independent entities like the Cochrane Collaboration, which can really improve the quality of their work.

All those three things—results reporting, clinical study reports, and the decisions and the reasons for them offered by the regulator—need to come in addition to clinical trial registration.

Ms. Eve Adams: Thank you very much.

The Chair: Next is Mr. Scarpaleggia.

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

I'm actually sitting in for the Liberal health critic today, so you'll have to excuse me if my questions seem a bit rudimentary.

At the moment clinical trial registration is not required. Do I understand that to mean that if a company is going to do a clinical trial it has to somehow inform the government? I'm not sure exactly what it means.

Prof. Matthew Herder: Clinical trial sites have to receive approval from the government to have a trial conducted there, but they don't necessarily have to comply with any registration requirements. It depends on that site, where it's being conducted in Canada.

Publicly funded researchers have to comply with registration requirements pursuant to the tri-council policy statement, but that doesn't capture trials that are privately funded, conducted by private research organizations, which is fairly common in Canada.

Mr. Francis Scarpaleggia: I see.

Where do we stand comparatively with other nations? If we strengthen this bill, would we become leaders? I'm simply trying to get a sense of how Canada is situated.

I don't know who wants to take that question.

● (0950)

Dr. Joel Lexchin: If you compare us with the United States and the EU, right now we're a distant third in terms of transparency. With the passage of Bill C-17, with the amendments that have been suggested, I think Canada would be leading both the U.S. and the EU. Right now, though, we're not doing very well in terms of transparency, disclosure of information.

Mr. Francis Scarpaleggia: If we passed Bill C-17 without the amendments, without strong amendments that have been suggested, would we be laggards? What I guess I'm getting at is whether this bill is simply a placebo, or is it going to make substantial progress anyway? Would we still be behind the United States and Europe, in terms of transparency, if we passed the bill without the amendments that you and others are suggesting?

Dr. Joel Lexchin: The bill is definitely a positive step, but right now the EU is willing to disclose clinical study reports. This bill does not mandate that, so I don't think—

Mr. Francis Scarpaleggia: Thank you, I appreciate that.

I find it odd as to why we don't have a stronger bill, because they're the same corporations that are in Canada. They benefit from the same trade law framework and they have the same concerns around intellectual property. I don't understand why we didn't level the playing field, since we're dealing with the same players. But anyway, that'll be a question for the government to answer.

In terms of your point about trade agreements, Professor Herder, do I understand that trade agreements are not an impediment to adopting the amendments that you and others have suggested, that it's only a question of getting the language right so that we protect your amendments and other amendments from trade challenges? Or is there an endemic problem here with trade agreements and ensuring the safety of patients?

Prof. Matthew Herder: That's my view.

Under trade agreements, Canada is required to put into place measures to protect data, essentially, which might capture, or some would argue does capture, safety and effectiveness data around a drug. But there are two exceptions to that commitment. One is where it's necessary to protect the public, so a public interest exception, and I would make the argument that it is absolutely the case that we have to have this information. Some would contest that. So what I tried to do is to base it on the other exception, where a government has put into place measures to protect that data against unfair commercial uses.

What companies are most worried about when you talk about transparency is that you're going to give a free ride to their competitors, especially generic companies. Canada has put into place through regulations under the Food and Drugs Act periods of data exclusivity, quite apart from patents and other forms of market protection that might be available to first-mover companies. There's a period of eight years in which the Minister of Health cannot issue a notice of compliance to a competitor in respect of the same drug under the Food and Drugs Act, when you're talking about an innovative drug. Because we've done that, because we've protected data against unfair commercial uses, it's my position that it's open to the government, completely consistent with our trade obligations, to make this information more transparent.

Ms. Sylvia Hyland: I have just a comment on one of your questions.

The Food and Drugs Act hasn't been amended in, I think, about 50 years. If you are asking, are we lagging behind? We are lagging behind a little in the authorities for Health Canada.

My understanding is that there were more complex bills proposed, Bill C-51, Bill C-52. They were comprehensive, complex, and they weren't enacted. This is a more simplified, to-the-point bill to take a step forward in safety in Canada.

Thirdly, Canada is leading in some ways already. There are only a handful of countries worldwide that post their adverse drug reaction reports online, available to the public and practitioners. Two other countries that I know of are the Netherlands and the U.K., and then there's Canada. We have taken some steps to show leadership worldwide. In the United States they do make the device incidents available online, but not the adverse reaction reports.

I just wanted to share with you a little bit about where Canada sits worldwide.

● (0955)

Mr. Francis Scarpaleggia: How much time do I have? None?

The Chair: Unfortunately, you're right out of time.

Mr. Young.

Mr. Terence Young (Oakville, CPC): Thank you, Chair.

I'd like to direct my first questions to Dr. Joel Lexchin with a brief introductory comment. We heard about 140 peer-reviewed papers that you authored or co-authored, and that you've been working on this issue for 30 years. I know that a significant part of your career has been against the current, especially in the early years when you were like a voice in the wilderness on drug safety. I wanted to thank you and congratulate you, on the record, for your work in leading this for so many years.

Could you please comment, Dr. Lexchin, on why transparency in clinical trials is important for patients? In other words, how will it net benefit patients and improve their health, and reduce adverse drug reactions?

Dr. Joel Lexchin: First of all, Mr. Young, thank you very much for the compliment. I would like to return it to you on the basis of your long and hard fight to get this bill before the House of Commons, and unfortunately, it had to result from the tragedy around your daughter.

Let me briefly outline one example of how better transparency would improve safety for patients. We all know that antidepressants —these are the selective serotonin reuptake inhibitors, Paxil—have been used widely off label for children. This is often because people.... Doctors are desperate and there aren't enough child psychiatrists around. It's going to take a year to get a significantly disturbed child into therapy. Doctors have been reaching for these drugs on the assumption that if they help adults, they may help children.

When somebody looked at the published data around this, around the SSRIs in general, what they came up with was the conclusion that these drugs have some benefit for children and they don't pose any significant safety issues.

However, when these same researchers were able to, through the U.S., get a hold of the unpublished trials that had been done, they came up with a much different conclusion. Their conclusion was that there was no evidence of any benefit for children and that there was the potential for significant harm.

This shows the problem with relying simply on the published information. It's the unpublished information.... There have been estimates that half of all the clinical trials that are done are never published. It's that kind of information that doctors need to be able to make the best informed decisions, so that they can give patients the best therapy, and also protect patients when they're getting the medications.

Mr. Terence Young: That's a terrific example.

Can you please comment on drug disasters? I wanted to ask you, if Bill C-17 had been law throughout the 1990s and clinical data had been published throughout the 1990s, how many or what drug disasters could have been avoided?

Dr. Joel Lexchin: There were a number of potential disasters that we might have avoided. One of them has to do with two drugs that are used to treat heart arrhythmias. These got to be widely prescribed by doctors, not for serious heart arrhythmias but for very minor heart arrhythmias. When the trials were eventually done to look at this issue, it turned out that these drugs were killing more people than they were benefiting.

Although not in the 1990s, we can look at Vioxx. Vioxx was approved in 1999 in Canada. By 2003 it was the 10th most widely prescribed drug in the country in terms of number of prescriptions, and in September 2004 it was pulled from the market because of the cardiac risks associated with it.

Finally, there is the question of the hormone replacement therapies that again were widely used by post-menopausal women. When the trial in the U.S., which had to be publicly funded because the companies were not willing to fund it on their own.... When that trial result was published it turned out that, yes, the hormone replacement did reduce fractures, but it also increased the number of cardiac problems and increased the number of strokes and it increased the number of people with breast cancer.

All of those could potentially have been avoided with better disclosure of information.

● (1000)

Mr. Terence Young: Thank you.

I'd like to give my next question to Professor Herder.

Professor, a big issue we have in clinical research is that the drug companies, their game is to start a clinical trial and ask the researcher to sign a contract, essentially a gag order, that if they order the trial to be stopped at any given time they must never talk about it again, that it will never see the light of day. That's because many of their trials will show that their drug is not working better than a placebo or that their new drug is actually harming patients and they want to cover that up.

Your recommendations for transparency, would they address the issue of where a trial is registered and stopped? Are you insisting or asking that even the partial evidence from that trial or the partial clinical data be published as well?

Prof. Matthew Herder: That's a great really specific question. I think the amendments I envision would certainly capture negative results, although I think some very careful thinking would have to be done in defining what a negative result is. I'm trying to capture all results, but if you don't have a result per se because they stopped the trial, when does that become reportable?

I think there would probably need to be some kind of specific time period that would have to be surpassed for the results or whatever was done before the trial was stopped to be reported, but I think what would capture the really worrisome examples would be if there was an adverse event of some kind, even in the context of a study. If they stopped it because there were very serious safety concerns, not just for commercial reasons or strategic reasons they didn't want to pursue that particular study, that should be reportable.

I think it can be done. I'm not sure the very specific wording I gave captured it exactly, but hopefully that could be defined by regulations.

Mr. Terence Young: Thank you.

The Chair: Thank you very much.

For anybody that needs translation, I'd recommend getting your earpiece ready, passing it out.

If you're good to go, carry on, Mr. Morin.

[*Translation*]

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

Can you all hear me in French?

[*English*]

Dr. Joel Lexchin: I'm afraid that I don't.

Mr. Dany Morin: Okay. So can we...?

The Chair: Try it again.

[*Translation*]

Mr. Dany Morin: Can you hear me in English when you use the earphones?

Mr. Lexchin, can you hear me in English?

[*English*]

Dr. Joel Lexchin: I haven't heard the interpreter at this point, I'm afraid.

The Chair: Okay. We're going to work on that just for a second.

I think what Mr. Morin was saying was that he thinks the Leafs are going to win the Stanley Cup next year, but I'm not quite sure. My French lessons are not quite at 100% yet.

● (1005)

Mr. Dany Morin: I challenge the chair.

The Chair: I'm pretty sure that's what he said.

Professor Graham, are you still on the line?

Prof. Janice E. Graham: Yes.

The Chair: Could you hear the translation?

Prof. Janice E. Graham: No, I didn't. I didn't hear the French either.

The Chair: Okay, we're going to let our technicians work on the issue.

Go ahead, Mr. Wilks, if you're ready to go, and then we'll go back to Mr. Morin afterwards, if that's okay.

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

Thank you, Mr. Morin.

I wanted to touch upon a couple things, and unfortunately, one of our witnesses left. One of the things that was brought up was the natural health products that were not included in Bill C-17 due to their low risk profile and the fact that they're already adequately regulated.

Ms. Hyland, do you agree with the approach, given the inherent low risk of natural health products? Perhaps I could listen to Professor Herder and Dr. Lexchin, and Janice Graham, who is online as well.

We'll start with Ms. Hyland.

Ms. Sylvia Hyland: I'm not sure the risks are lower. Our position is the understanding that the inclusion of natural health products in the more complex bills cause them not to move forward and be enacted. Bringing that into this bill might actually slow down the great work that's already been started. So maybe the natural health products do need to be dealt with, but in the future...to take Bill C-17 and take this first step forward. So I do think they will need to be looked at, but I'm not sure we need to bring them in right now to Bill C-17.

Does that help?

Mr. David Wilks: That does help, thank you.

Professor Herder.

Prof. Matthew Herder: I share the view that it's not clear to me that they are inherently less risky. For that reason, I think they should be regulated very carefully. I think it's more of a strategic consideration in some ways, as my friend just intimated, although I'm not sure it's that difficult to fix this part of the bill. As I look at the bill just quickly, it just excludes natural health products from the definition of “therapeutic product”. So, if that wording was simply removed, if the committee was motivated to hold natural health products to a higher standard, perhaps the new measures that are included in the bill could be applied against natural health products.

Mr. David Wilks: Dr. Lexchin.

Dr. Joel Lexchin: I certainly think we need more information about natural health products. I work in an emergency department. When people come in and they say they're taking various natural health products, I really have no idea of, one, the inherent risks associated with those products, and two, how those products interact with any prescription drugs that those people may be taking.

I'm not alone. I think most of my colleagues are in the same position. We definitely need more information about the safety of these products. But I think one of the things that killed Bill C-51 was the opposition from the natural health products community. I would hate to see Bill C-17 killed because of that same kind of opposition. I think we need to move forward with better regulation of natural health products. But I agree that I think it can be done at a later date.

● (1010)

Mr. David Wilks: Thank you.

Professor Graham.

Prof. Janice E. Graham: Thank you. It's a very good question, Mr. Wilks. Thank you for asking it.

I was researching at Health Canada when the natural health products directorate was brought into being. At that point in time, Canada was a world leader, and it remains a world leader in having a natural health products directorate. Unfortunately, and I will say it here, they caved to industry pressure—and I'm talking about the natural health products industry—and removed issues of efficacy from approvals. So unlike biologics and pharmaceuticals, NHPs or natural health products don't actually need to have the stamp of showing that they are an efficacious agent.

Mostly people were worried about safety, and I share all of my colleagues' concern that many of the natural health products aren't all that safe. This is something that is recognized everywhere in the world.

I was in West Africa last month and watched a little boy writhing on the ground after he had to have a terrible abscess removed without painkillers, because the nurse in this tiny clinic without electricity recognized that these kids were coming in and.... People first go to what in Canada is the medicine cabinet or to what anywhere else is the local herbalist and pick up whatever they have. When they finally go as a last effort to the emergency ward, the emergency people can't treat them, because they don't know what they've taken.

I think the issue of natural health products would very easily derail all of our interests in getting the amended Bill C-17 forward, but I would like to leave it off for now, because we want to see Bill C-17 amended and approved.

The Chair: Thank you very much.

Thank you, Mr. Wilks.

Mr. Terence Young: Mr. Chair, I have a point of order.

Professor Gibson made a really brief remark on natural health products, and I could tell she wanted to say more. I wonder if we could ask the clerk to write to Professor Gibson to ask her if she wouldn't mind submitting further remarks in addition to her brief comments on the record about natural health products and Bill C-17.

The Chair: We can certainly ask her to do that and will make sure that the analyst gets it in her hands, too.

Okay, Mr. Morin.

We'll give it another go here, ladies and gentlemen.

Dr. Lexchin and Ms.Graham, would you give us an indication once Mr. Morin starts whether you're getting it in English or not?

[*Translation*]

Mr. Dany Morin: Can you now hear me in English when you use the earphones?

[*English*]

Prof. Janice E. Graham: Yes, I do.

Dr. Joel Lexchin: There were only a few words from Mr. Morin. I didn't hear any English associated with it. Perhaps if he says a little more, I can tell.

[*Translation*]

Mr. Dany Morin: That is not a problem. If you wish, I can speak in French longer.

Can you now hear the simultaneous interpretation?

[*English*]

Dr. Joel Lexchin: That's fine. I can now hear in English. Thank you.

[*Translation*]

Mr. Dany Morin: I am very happy about that.

Thank you for giving me the opportunity to speak my native language.

My first question is for Mr. Lexchin and Mr. Herder. Other witnesses may also make comments on this.

Earlier, we spoke about a contraceptive pill which, according to the old definition which is not included in Bill C-17, meant that a pregnancy was considered to be the consequence of a life choice. So, according to the new definition we find in the bill before us, are there other concrete examples of medications which were mistakenly classified?

In other words, will the new definition solve other situations we may have seen in Canada, aside from the contraceptive pill which was used as an example previously?

● (1015)

[*English*]

Prof. Matthew Herder: Perhaps I can speak first.

I think the point Professor Gibson was making was around restrictive interpretation of harm or injury. Her point was that without clear guidance, harm or injury encompassed products that had been mislabelled or mispackaged and that therefore wouldn't work as a result, as was the case in a contraceptive pill, which they may not include in the definition of “harm”.

With the definitions that are in Bill C-17 and with the additional wording that she proposed for circumstances in which they may not work because of mislabelling or mispackaging, the bill would capture other things as well as adverse drug reactions—the more traditional kinds of harm.

I'm not sure that I have squarely addressed your question, but I think we're there in terms of what has been offered.

[*Translation*]

Mr. Dany Morin: In the history of Canada, do you know of any other concrete cases of this type of problem, or was this type of decision only made for one medication?

[*English*]

Prof. Matthew Herder: I think there have been other examples where there hasn't been quick action by the regulator because there's been a dispute or a discussion about whether the harm is clearly owing. Diane-35 was another medication that's commonly used to treat acne that has received some attention in the last year or so. Really the delay that people were concerned about stems from a lack of a power to issue a recall without the permission of the manufacturer. That's what's in this bill.

That's one example. I don't know if Dr. Lexchin can offer others.

Dr. Joel Lexchin: I don't know of any concrete examples, but one of the problems with getting concrete examples is that it's very difficult to get information from what Health Canada publishes about drugs that it has withdrawn from the market for safety reasons. In fact, Health Canada does not currently have such a list. If you want to know what drugs or how many Health Canada has withdrawn from the market because of safety problems, say in the past 20 years, you have to go into and search through 20 years of reports from Health Canada to compile such a list. Health Canada doesn't maintain that on its own.

[*Translation*]

Mr. Dany Morin: Thank you.

Doctor Herder, you spoke earlier about post-marketing trials.

In Canada, how important is it to crack down on pharmaceutical companies by forcing them to release the results of other trials once the medication is on the market?

[*English*]

Prof. Matthew Herder: I think it's essential to do a couple of things. One is to ensure that any such conditions placed on a licence to market a drug and to keep doing post-market studies be made publicly known so that others can both hold the company to account and the regulator to account to be following up on those particular conditions.

Then, if those studies are done but not necessarily published, that information should be communicated to Health Canada. If Health Canada has the ability to disclose that information because it's making ongoing decisions perhaps to transition a conditional licence to a licence without any more conditions because this post-market study has been fulfilled, then it would have to disclose that at that point. So the specific recommendation I made about making sure that Health Canada's decisions are transparent would hopefully enable the regulator to put up any post-market studies that are done. Even if the company doesn't take it upon itself to publish those on its own, the regulator could do that on its behalf.

The Chair: Thank you.

Mr. Gravelle, you're up next, sir.

Mr. Claude Gravelle (Nickel Belt, NDP): Thank you, Mr. Chair.

Could you let me know when there's only one minute left, please?

Mr. Lexchin, I'm not sure if I heard you correctly so I'm going to ask you to maybe repeat it. I think I heard you say that Health Canada allows Canadians to take drugs that health care knows nothing about. Did I hear you correctly?

● (1020)

Dr. Joel Lexchin: No. For any new prescription or in fact non-prescription drug to reach the market, Health Canada has to evaluate the information that the companies submit about those drugs.

The problem is that the trials that are done before a drug is on the market are relatively restricted kinds of trials. They tend to be for short periods of time. They tend to be done on very limited populations, typically middle-aged men and women who are not taking any other drugs and who don't have any other conditions that may interfere with detecting whether or not the drug works.

So when these drugs come on the market, we actually know very little, especially about their safety or about how they're going to work in a wide range of people. For instance, if the drug has only been studied in middle-aged people, what's it going to do to your 85-year-old grandmother who's already taking five or six other medications, or what's it going to do with your eight-year-old daughter? We don't know those kinds of things.

That's one of the reasons why we definitely need these post-market studies to acquire this additional information to be able to be sure that the drugs are used in the most effective and safest way possible.

Mr. Claude Gravelle: Thank you.

You also talked about trials that are funded by drug companies as compared to trials that are funded independently. So what's best for Canadians, trials that are funded by drug companies, or by independent companies?

Dr. Joel Lexchin: Well, right now the money to do the trials is primarily with the drug companies. A trial can cost in the range of $150 million. The total CIHR budget, I think, the last time I looked, is about $900 million, and that's for all of the research that it funds, not just drug trials.

So, the drug companies have the money to do the trials, but the drug companies also have a dilemma. One, they have a duty to their shareholders to make sure the company's value increases, and two, they have a duty to doctors and the public to make sure information is reported accurately and completely.

Sometimes, based on what we've seen in the United States, as a result of the lawsuits brought against companies by the justice department, those conflicts are resolved in favour of keeping information secret. The drug companies can continue to fund the trials. But as I said earlier, what we need is a barrier put up between paying for the trials and selecting who designs, carries out, and analyzes the trials. So that's why I was suggesting that the drug companies would give the money to an independent organization, like CIHR, which would then use a peer-reviewed process to decide who should conduct them.

Mr. Claude Gravelle: Thank you very much.

I only have one minute left, so I'd like to ask each witness here today, starting with Ms. Hyland, if the suggested amendments would make this bill better.

Ms. Sylvia Hyland: I believe that—

Mr. Claude Gravelle: Keep in mind that I only have one minute.

Ms. Sylvia Hyland: Okay, so can I wait for a moment and just compose my thoughts? I want to give a thoughtful answer.

Prof. Matthew Herder: Absolutely. Bill C-17 is strong as it stands. It could be made really strong if the amendments are included.

Mr. Claude Gravelle: Mr. Lexchin.

Dr. Joel Lexchin: I agree with what Matthew Herder said.

Mr. Claude Gravelle: Ms. Graham.

Prof. Janice E. Graham: Absolutely.

Mr. Claude Gravelle: Back to you....

Ms. Sylvia Hyland: I agree more can be done, and I think maybe we need to do it in a staged approach. My concern is that amendments could delay getting some of these key authorities in place sooner, so that's my only concern. I think there's always room to improve. There will always be ongoing improvement that's going to be needed, and there'll be more changes needed to the Food and Drugs Act. But I'm not sure we want to delay implementing some of these key components of Bill C-17.

I liked hearing that there's agreement that it's a very strong bill.

● (1025)

The Chair: Very good.

Mr. Lunney.

Mr. James Lunney (Nanaimo—Alberni, CPC): Thank you very much, Mr. Chair.

Thanks to our witnesses here.

Just a comment, as we get going here.... I have some questions for our witnesses.

The reason NHPs were removed from the bill is that NHPs are fundamentally different from prescription drugs in the following way. They're vitamins. They're minerals. They're natural molecules. They're common in biological systems—amino acids, and so on. Therefore, the practitioners would call them orthomolecular because they're in their natural state. Anything we have under the drug regime that is patented can't be used in a natural state. So they find that molecule and have to change it somehow, by methylating, hydrogenating, carboxylating, or somehow changing it so it's like the original but different, in order to patent the process. That fundamental difference makes a whole big difference in the profit that's available from a patented product, but it also increases the risk. Anyway, I just put that out there as one of the reasons why they're in a separate regulatory regime, which has been one of the strongest regulatory regimes in the world right now.

Dr. Lexchin, you referred to a couple of examples that are used. SSRIs, antidepressants, are often used off label for adolescents and children; and the published data and the unpublished data, when you compared them and put them together, gave a very different perspective. You mentioned HRT as an example, that it was learned, I think, that there is a 40% increased risk of cardiomyopathy and of ovarian and breast cancer. Maybe you can correct me on that. It seems to me 40% was roughly the increased risk. But are you aware, Dr. Lexchin, about studies linking stomach acid suppressants, particularly proton pump inhibitors, with C. difficile?

Dr. Joel Lexchin: I've read a little bit about that, but I wouldn't be able to comment on—

Mr. James Lunney: Let me be more specific when I say the published literature—and this is on the FDA website—gives a 40% to 275% increased risk, dose dependent, time dependent, dose response fashion, because the longer you're on the medication the higher the risk, and the higher the dose, the greater the risk of an infection that could extend your hospital stay by three weeks and result in expensive treatments with antibiotics, and perhaps bowel surgery, and perhaps death.

Would you consider 40% to 275% to be clinically significant?

Dr. Joel Lexchin: Definitely, yes.

Mr. James Lunney: Okay. Thanks for that.

Well, we have a nosocomial surveillance infection program here in Canada, 58 teaching hospitals. They've been monitoring this for more than a decade, but apparently they were not collecting data on the meds that people were on at admission, when they developed antibiotic-associated diarrhea or CDAD. Would you consider that a missed opportunity?

Dr. Joel Lexchin: Yes. I think that we need better sources of data than we currently have.

For instance, in most provinces there is no single source where you can find out prescriptions that have been dispensed. British Columbia is an exception. Their PharmaNet program records every prescription that has been dispensed, regardless of who has been paying for it. That kind of information, coupled with the hospital and outpatient databases that we have, could certainly help in providing more information about drugs that are being used and their adverse consequences if they occur.

Mr. James Lunney: Thank you for that.

I appreciate your remarks about the Cochrane Collaboration and what they determined about the increased risk, or at least when the studies were funded solely by pharmaceutical companies that there was more likelihood they would be more positive in the conclusions.

I wanted to ask you, sir, and our other witnesses here, about a point that Elaine Gibson raised. I'm sorry she's not here to develop this. That was the question about expanding the application to all holders of therapeutic products, rather than only the sellers. Is that an issue?

Maybe I'll turn to Mr. Herder. Is that something on your radar? Do you think that's a point we should follow up on?

● (1030)

Prof. Matthew Herder: Yes, I do.

That was in the paper that Joel, Janice, Elaine, and myself, and Barbara Mintzes published. That was one of the points we thought should be addressed in the bill, simply to make it absolutely plain that other corporate actors in the production chain and distribution chain that have pharmaceuticals, if they have them in their hands and there's a recall on that particular drug, they're subject to that recall as well.

The Chair: Mr. Lunney, you're over time. Thank you.

Ms. Davies.

Ms. Libby Davies: Thank you very much.

I'd like to come back to one of the points you made, Matthew. You laid out your four points about transparency, registration of all clinical trials, that there should be mandatory disclosure of all studies and reports, penalties for non-compliance, but the third one, Health Canada to report all decisions and the reasons behind the decisions.

I think we've been looking at this issue and sort of saying there has to be a lot of onus on the pharmaceutical companies and so on, which clearly is critical. In fact, the more we learn about this issue, the more it is so disturbing about how little knowledge there is in the public realm about what goes on. Hopefully, this bill will be able to address that.

In terms of the role that Health Canada plays, we haven't focused on this a lot. What happens now? If your amendment or your suggestion is incorporated, how would you actually see that working in terms of timeliness in getting information out? You may be familiar that the Auditor General, in 2011, issued a report saying that it could take up to two years, even under the status quo, for information to get out to people about adverse reactions.

If we adopted this in principle and tried to get an amendment, how would you see it working in terms of ensuring that there's a streamlined flow of information, and that the system doesn't become, in effect, paralyzed because everybody is waiting for somebody else to get their piece of information out there?

Prof. Matthew Herder: Thank you for the question.

I think it's critical to think about transparency in terms of the institutional picture that Health Canada presents, compared with other regulators. Just thinking about it on its own, it clearly does not necessarily have as many resources as would be helpful to deal with some of these issues.

But when we're thinking about writing decisions in particular, the best evidence we have so far, which Dr. Lexchin mentioned in his remarks, is around the summary basis of decisions. Those documents tend to suffer in terms of what they actually contain, but also they're slow and they don't come out readily.

To me, what I'm trying to get at when I say “the reasons behind them” may be a lot of the data, more so than the logic and the description, although that would be nice, too. But if it's a matter of describing and just putting forward the data that was shared with them by the manufacturer, in theory that might be more efficient than what we have now, where you have this sort of very technical process. You're drafting, probably revising, a tonne, the reasoning. I think there could be a more simplified form that talks about the reasons why the risks were considered to outweigh the benefits, and then the actual data as being the reasons as well, so that is more carefully reported. As Dr. Lexchin showed, the very basic information about the sex of the participants in the trial, how long they stayed in, and so on, is often missing. Just putting information that actually shouldn't be that resource-intensive to collate would be very helpful.

Ms. Libby Davies: That is very helpful.

Just to follow up, are you concerned at all about the level of resources within Health Canada to take this on?

We did ask this of officials last Thursday, and the response we got was, “Well, they've made some efficiencies and they've changed the way they do things since 2011, so things are better now”. But I think this bill will only be as good as how it is implemented, and that does require resources to do the follow-up work, particularly when it comes to transparency at Health Canada.

Do you have any concerns about the resourcing for this bill in terms of who the heck is going to stay on top of it and follow up all of this work that needs to be done?

Prof. Matthew Herder: Absolutely, but it's not clear to me that fewer resources means less transparency. I think it might mean the opposite.

But specifically, disclosure of clinical study reports—these are things that are provided by the company—if Health Canada is looking at this as something that they have to craft and massage and at the resources that will take, yes, that is scary, and they may never get those resources. But if it's empowered to release information that by definition, under the statute, it already has to have from the manufacturers, then you could have greater transparency, in theory, with fewer resources needed.

● (1035)

Ms. Libby Davies: Okay. Thank you for that.

The Chair: Mr. Lizon.

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

Welcome to all the witnesses.

I would also like, Mr. Chair, to have an indication when I have one minute left. Thank you.

The first question I have is to Professor Lexchin on the mandatory provision that the results of a clinical trial be made public within one year.

Who would have access to that information? It's useless for the general public, of course. In your view, who should have access, and under what rules? On the one hand, there is the greatest benefit possible for the potential patients, and on the other hand we don't want to have anybody using it for unfair commercial practices.

Dr. Joel Lexchin: I think that Professor Herder outlined some of the steps that Health Canada or Canada has already taken in terms of data protection to try to ensure that the information is not used for unfair commercial purposes. In terms of the full results of the clinical trials that have been undertaken, we could initially look at what I described with respect to the model that GlaxoSmithKline has committed to, which is that they will release all of the data on critical trials once researchers have made an application and that application has been vetted by an independent committee so that you get this information out there to the people who will be able to use it.

For instance, ISMP may be interested in that information in terms of developing strategies for better patient protection. CADTH, which evaluates new drugs and technologies, may be interested in that information so that it can write its reports. Other groups in Canada that develop guidelines for clinical practitioners may be interested in that information so that they can include all of the relevant information when they make their recommendations to doctors around how to prescribe drugs most appropriately.

Mr. Wladyslaw Lizon: Professor Herder, you did mention that the trade agreements should not contravene this bill; however, you said it may be contested. I don't know what information is included in a clinical trial report. But in the trade agreements between the countries, there is a provision of data protection and patent protection for drugs—I don't know whether it's eight or 10 years.

Is there anything in a clinical trial report that would be under that data protection?

Prof. Matthew Herder: I think it's important to keep in mind a couple of things. One is that there are these international agreements that create minimal requirements around intellectual property. You have to have a patent system. You have to put into place, as you say, measures to protect data. But they don't necessarily determine what your patent system looks like and what the requirements in your particular country for patenting are.

If there are differences between countries, companies often contest those. There's always a fight around it, but there's flexibility for a sovereign nation to define its own standards. So in the case of data that might be in clinical study reports, yes, it could conceivably be argued it's data that ought to be protected. It is scientific information. The definition of data is pretty sort of literal. If it's been treated as confidential, then companies will make that claim.

But if we've taken steps that we have as a country to protect data, or, which I would suggest is also true in this case, it is necessary to protect the public health, you can override any data protection or make that information available for the public. So it might be treated as confidential data by the company but it remains open to Canada to disclose that information.

● (1040)

The Chair: Thank you, Mr. Lizon.

Mr. Young.

Mr. Terence Young: Thank you, Chair.

I'd like to ask Dr. Lexchin about off-label prescribing. You've written about it many times over the years, Dr. Lexchin. I know that approximately 70% of doctors prescribe off label at least part of the time or some of the time. I'm not suggesting that it's all bad because it's relatively common. But it can be much riskier for patients because first, the drug was not proven safe and effective for that condition. It's driven by or stems from, in many cases, illegal marketing. That is, the drug reps in the doctors' offices whispering in their ears or taking them to lunch or getting them to prescribe the drug for something that isn't proven safe. Third, it's driven primarily, on the drug company side at least, to create blockbuster drugs that sell $1 billion a year or $2 billion or $3 billion or $4 billion.

Recognizing that it's a provincial jurisdiction, do you feel that the powers included in Vanessa's law, allowing the minister to require additional testing, will be helpful in addressing inappropriate off-label prescribing?

Dr. Joel Lexchin: I definitely do.

For instance, if we have evidence of widespread off-label use of drugs, Bill C-17 would then allow the minister to require companies to undertake additional studies so we can gain better information about whether or not that off-label prescribing is or is not appropriate.

Currently, the estimates are that 70% of all of the off-label prescribing is not backed up by good scientific data. That doesn't mean, as you pointed out, that off-label prescribing is bad for people; it just means that we don't know. We need to be able to have the requirements to get that information to decide whether this off-label prescribing is good or not.

However, another provision we need to consider is that although Health Canada collects data in its adverse drug reaction reports about whether or not the drug has been prescribed on or off label, when that information is provided to them, that is not part of the online database. People don't really know how often adverse reactions are linked to off-label prescribing. That could be quite easily corrected by giving Health Canada the resources, or requiring Health Canada to post on its public database whether or not the drug was being prescribed on or off label.

Mr. Terence Young: Thank you very much.

Dr. Lexchin, you've also written very extensively about the extent of adverse drug reactions in Canada, and, in fact, North America. We know, and you have written evidence from the Lazarou study, at the University of Toronto, that prescription drugs used as prescribed, the right way, are the fourth leading cause of death in North America and the cause of millions of adverse drug reactions.

If Vanessa's law was passed with your recommended amendments. or close to them, how would modern medicine change in Canada?

Dr. Joel Lexchin: We will never get to the point where there's absolute safety. That doesn't exist. But certainly the estimates are that somewhere around 60% of adverse drug reactions can be prevented, and one of the ways of preventing those is by having better information about when they occur and who they occur in.

By virtue of Vanessa's law and increasing the amount of safety information we acquire, we can probably prevent a significant number of those adverse drug reactions and reduce hospitalizations and mortality. The exact amount is difficult to determine, but there would be significant reductions, in my view.

● (1045)

Mr. Terence Young: Thank you very much.

Could you please describe the worst-case example that you've seen of widespread off-label prescribing that has led to patient harm?

Dr. Joel Lexchin: I suppose what I've seen that's most likely to lead to patient harm is the inappropriate use of antibiotics for viral conditions or where there's no infection in the first place, or where the wrong antibiotics have been chosen and that leads to cases of C. difficile. C. difficile, especially in the elderly, can be very difficult to treat and can require prolonged hospitalizations, or as your colleague said, can lead to death.

Mr. Terence Young: Thank you.

The Chair: That concludes our meeting for today. We'll see everybody back on Thursday.

The meeting is adjourned.