ISSN 1710-9477

Legislative Assembly of Ontario

Second Session, 40th Parliament

Assemblée législative de l'Ontario

Deuxième session, 40e législature

Official Report of Debates (Hansard)

Tuesday 30 April 2013

Journal des débats (Hansard)

Mardi 30 avril 2013

Standing Committee on Social Policy

Oversight of pharmaceutical companies

Comité permanent de la politique sociale

La surveillance, le contrôle et la réglementation des entreprises pharmaceutiques

Chair: Ernie Hardeman
Clerk: William Short

Président : Ernie Hardeman
Greffier : William Short

Hansard on the Internet

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. The address is:

Le Journal des débats sur Internet

L'adresse pour faire paraître sur votre ordinateur personnel le Journal et d'autres documents de l'Assemblée législative en quelques heures seulement après la séance est :

http://www.ontla.on.ca/

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-3708.

Renseignements sur l'index

Adressez vos questions portant sur des numéros précédents du Journal des débats au personnel de l'index, qui vous fourniront des références aux pages dans l'index cumulatif, en composant le 416-325-7410 ou le 325-3708.

Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Tuesday 30 April 2013

Mardi 30 avril 2013

The committee met at 1600 in committee room 1.

OVERSIGHT OF PHARMACEUTICAL COMPANIES

PETERBOROUGH REGIONAL HEALTH CENTRE

The Chair (Mr. Ernie Hardeman): I call the meeting of the Standing Committee on Social Policy to order. We are here to do a study relating to the oversight, monitoring and regulation of non-accredited pharmaceutical companies.

Our presentation today will come from the Peterborough Regional Health Centre. In fact, they were here before I got here, and I got here quite a bit earlier. I'm glad to see we're here and already all seated there.

We will be doing the hearing under oath, so the Clerk will ask each one of you to either affirm or swear the oath, and then we will start the process.

The Clerk of the Committee (Mr. William Short): We'll go left to right. Mr. McLaughlin, did you want to swear the oath or be affirmed?

Dr. Peter McLaughlin: I will be affirmed.

The Clerk of the Committee (Mr. William Short): Okay. If you could just raise your right hand, please.

Mr. McLaughlin, do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Dr. Peter McLaughlin: I do.

The Clerk of the Committee (Mr. William Short): Thank you.

Ms. Freeman?

Ms. Laura Freeman: I'll swear an oath.

The Clerk of the Committee (Mr. William Short): Okay. The Bible is in front of you there. Thank you.

Ms. Freeman, do you solemnly swear that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth, so help you God?

Ms. Laura Freeman: I do.

The Clerk of the Committee (Mr. William Short): Thank you.

Mr. Tremblay, did you want to do the oath as well?

Mr. Ken Tremblay: I'll affirm.

The Clerk of the Committee (Mr. William Short): You'll affirm. Thank you.

Mr. Tremblay, do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Mr. Ken Tremblay: I do.

The Clerk of the Committee (Mr. William Short): Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much again for being here. We will have 20 minutes for you to make your presentation, and you can use that in any way. All three can speak or one can speak. At the end of your presentation, we will then have questions. We'll start with the official opposition, and each party will have 20 minutes to ask any questions on your presentation and any question relating to the issue at hand.

With that, the floor is yours.

Mr. Ken Tremblay: Thank you very much, Mr. Chair, ladies and gentlemen of the committee. On behalf of the board, the leadership team, and staff and physicians, thank you very much for the opportunity to provide this committee with information around the recent chemotherapy drug incident.

I'd like to begin by introducing myself and colleagues from the Peterborough Regional Health Centre.

My name is Ken Tremblay. I took over as president and CEO of PRHC in 2010. Since receiving my master's in the good old days of 1980, I've had the privilege of being the president and CEO of St. Joseph's Hospital in Brantford; York Central Hospital, now Mackenzie Health, in Richmond Hill; St. Boniface Hospital, a teaching hospital in Winnipeg; recently the Chatham-Kent Health Alliance; and now Peterborough.

Sitting to my right is Laura Freeman, vice-president responsible for clinical services, including cancer care. She joined PRHC in December 2010 from the Royal Victoria hospital in Barrie. She has held senior positions at the Northeastern Ontario Regional Cancer Centre and has completed an advanced health leadership program at the Rotman School of Management, University of Toronto.

Dr. Peter McLaughlin is our chief medical officer, chair of our medical advisory committee and vice-president responsible for clinical and support areas, including pharmacy. Dr. McLaughlin was formerly a professor of medicine, University of Toronto, and a staff cardiologist at the University Health Network. He remains an adjunct clinical professor of medicine at the U of T. He is a fellow of the Royal College of Physicians

and Surgeons of Canada and the American College of Cardiology. He undertook postgraduate training at the Ottawa Civic Hospital, Toronto General Hospital and Stanford University Medical Center in California.

Brenda Weir is the director of emergency, lab, diagnostic imaging and pharmacy at the Peterborough Regional Health Centre. She is a registered nurse by training, with 24 years of hospital leadership experience.

Margot DaCosta is director of renal, metabolic and cancer care programs at PRHC. She is a registered nurse with 25 years' experience.

Also joining us is Arnel Schiratti, who is director of strategic communications and engagement. His public sector career spans some 12 years in the Ministries of Health and Energy, Science and Technology, with nearly 10 years of hospital communications and engagement experience.

Laura, Peter and I appreciate the opportunity to make brief opening statements.

I wish to begin by recognizing that the committee has already heard from a number of provincial organizations and hospitals prior to our appearance. We will attempt to avoid unnecessary duplication for the committee.

To give you some specs about the organization, we're a regional health centre, about 400 beds, providing regional and locally focused health services to up to 600,000 residents. We have some 2,000 staff, 350 physicians and 600 volunteers on staff who are focused on providing high-quality, safe care in such areas as emergency, surgery, general medicine and regional services. Regional services include dialysis, stroke, mental health, diabetes, cancer care, vascular surgery and cardiac care.

More specifically, with respect to our role in cancer care and our cancer care clinic, it has grown by some 85% in the last five years. Each year, our organization performs about 640 cancer surgeries; 20,700 chemotherapy treatments for nearly 6,700 patients; screening services, like colonoscopies—about 500 of those; 2,600 colposcopy screens; and 7,800 breast-screening visits. Soon, in the next few months, we'll be opening our new radiation cancer suite, bringing additional cancer care closer to home for some 300 patients annually.

Our current and expanding cancer role would not have been possible without the support of Cancer Care Ontario and the Central East Regional Cancer Program, based at the R. S. McLaughlin Durham Regional Cancer Centre in Oshawa. I understand they were before you on April 23. Through the support of their cancer physicians, medical oncologists and radiation oncologists, and other clinicians and specialized clinical support personnel, we are able to serve cancer patients closer to home.

Our relationship, along with individual and mutual accountabilities, is guided by a memorandum of understanding between ourselves and the respective centres. In practical terms, through the Durham Regional Cancer Centre, cancer specialists and pharmacists come to Peterborough to care for patients and provide medical oversight to our nurses and clinical support staff, such as pharmacy assistants.

More specifically, as it relates to chemotherapy at PRHC, medical oncologists—physicians—from the DRCC assess patients, determine their course of treatment and oversee patient care at PRHC.

PRHC's nurses administer treatments ordered by these specialist physicians. Pharmacy assistants and technicians employed by the organization gather and, in some cases, prepare drug regimens under the guidance and direction of pharmacists from the Durham Regional Cancer Centre. The Durham Regional Cancer Centre supplies these drugs to PRHC through its various supply contracts.

Now it's my pleasure to pass this on to Laura, who will make her comments.

Ms. Laura Freeman: Thank you, Ken, and good afternoon, members of the legislative committee. As vice-president responsible for clinical services such as cancer care at the Peterborough Regional Health Centre, I wish to focus on the chronology of events in the identification and reporting of the incident and the steps staff and officials of PRHC took to contain the impact on our patients and notify the supplier and Durham Regional Cancer Centre.

You have heard from Cancer Care Ontario, the Ministry of Health and Long-Term Care, the Ontario College of Pharmacists and other impacted hospitals. Therefore, in the interest of time, I will attempt to limit the review of events to those that occurred at PRHC prior to April 2, 2013.

Peterborough Regional Health Centre's supply of chemotherapy drugs is through our relationship with the Durham Regional Cancer Centre. We receive our drugs under their contract.

On March 20, 2013, the supply of gemcitabine from the previous supplier, Baxter, had been depleted and the new supply of gemcitabine from the new supplier, Marchese, was used for the first time that afternoon at 2:20 p.m. At that time, the pharmacy assistant noticed that the label on the Marchese product differed from the labelling on the Baxter product. The Baxter and Marchese product labelling were compared, since the Baxter bag was still available.

The Marchese label indicated: gemcitabine, four grams in 100 millilitres only. The Baxter label indicated: 4,000 milligrams; total volume, 105.26 millilitres; gemcitabine, 38 milligrams per millilitre.

The pharmacy assistant noted that the Marchese label indicated 4 grams in 100 millilitres and began to question if that was the total volume and what the final concentration per millilitre was.

The pharmacy assistant also noted that the electronic preparation worksheet used to calculate the dose used 38 milligrams per millilitre, which had been the Baxter final concentration of four grams in 105.26 millilitres. The pharmacy assistant questioned whether the final concentration was 40 milligrams per millilitre.

1610

The on-site Durham Regional Cancer Centre pharmacist was called and consulted regarding the bag labelling

and the concentration, and if the electronic worksheet had been corrected for concentration of the gemcitabine Marchese bag. The Durham Regional Cancer Centre pharmacist instructed the PRHC pharmacy assistant to hold the treatment until hearing back from them.

The DRCC pharmacist consulted a second DRCC pharmacist, questioning the worksheet concentration for the gemcitabine Marchese bag. The PRHC pharmacy assistant consulted the PRHC senior pharmacy assistant regarding the concentration of the Marchese bag. The senior pharmacy assistant noted that the Marchese product was mixed in a Hospira bag, which has a known overfill of seven millilitres. It was not clear from the labelling on the Marchese bag if the overfill had been included in the determination of the final concentration.

Marchese was called and the senior pharmacy assistant asked about the concentration. When asked about the overfill changing the concentration, Marchese staff indicated that it was still four grams in 100 millilitres. They asked if the pharmacy assistant would like to speak to a Marchese pharmacist, and we agreed.

The PRHC manager of cancer care was made aware by the pharmacy assistant that there was a potential issue with the gemcitabine and they were working to find out further information.

A Marchese pharmacist contacted the PRHC pharmacy assistants and they advised that the final concentration would not change because the entire contents would be administered to the patient. The pharmacy assistants explained the process for the dose delivery: that the patient would not receive the entire contents of the bag and that the entire four grams would therefore not be given to a patient. The Marchese pharmacist stated they would need to investigate further.

At 4:05, the on-site DRCC pharmacist received a call from another DRCC pharmacist and was instructed not to use either the Marchese gemcitabine or cyclophosphamide prepared products.

At 4:10, the on-site DRCC pharmacist emailed the PRHC cancer care pharmacy team that the supply of the gemcitabine and cyclophosphamide product from Marchese were not to be used until further clarification about the exact concentration of the drug in the bags could be confirmed. PRHC discontinued immediately the use, and the supply of gemcitabine was quarantined in the PRHC pharmacy.

At 4:58 p.m., the senior pharmacy assistant received an email from Marchese indicating that they were working on a solution and would provide follow-up.

On Friday, March 22, at 1:34 p.m., PRHC manager of cancer care received a call from Dr. Leta Forbes, chief medical oncology at the DRCC, confirming an issue with respect to the concentration of gemcitabine and cyclophosphamide supplied by Marchese. She confirmed that PRHC had one patient who had received the Marchese gemcitabine in question as part of their treatment.

Late that day, I was informed in person by Tom McHugh, regional vice-president, cancer, at DRCC that Peterborough had one patient affected and that DRCC had ongoing investigations.

We followed the coordinated process and timelines for informing patients affected and communications established by DRCC.

The medical oncologist met with the PRHC affected patient on April 2, 2013.

PRHC ensured all cancer care staff were informed and able to answer questions and concerns raised by patients coming to the hospital for care, as well as those calling to make inquiries.

Margot DaCosta, the director of renal, metabolic and cancer services, is also here to assist us with responding to the committee's questions.

And now, Dr. Peter McLaughlin would like to make a final address.

Dr. Peter McLaughlin: Thank you, Laura

Mr. Chair, ladies and gentlemen, as Ken said, I am the chief medical officer for PRHC and have additional duties for quality, risk and safety as chair of the medical advisory committee, and VP for the emergency department, quality, risk and clinical support services like labs, diagnostic imaging and pharmacy.

I also wish to recognize my colleague Brenda Weir, our director of emergency, labs, DI and pharmacy.

In light of the innovative relationship between PRHC and the Durham Regional Cancer Centre, I wanted to take a few moments to briefly outline for the committee the interprofessional, inter-organizational and, in practical terms, the professional responsibilities of the many health professionals involved in the care of our cancer patients.

Patients are generally referred to our cancer program through their family physician or primary care provider. Following a series of tests and upon determination of a cancer diagnosis, a treatment plan is ordered by the appropriate specialist. In the case of chemotherapy treatment, this physician is a medical oncologist from the Durham Regional Cancer Centre who is jointly appointed to Durham Regional Cancer Centre and PRHC. These specialists see patients in both Oshawa and Peterborough.

As determined by the patient's needs, the medical oncologist may prescribe a chemotherapy drug regimen. This order is reviewed by the DRCC's pharmacists and, in turn, prepared by one of PRHC's pharmacy assistants for administration to the patient by a nurse employed by our hospital.

Each health professional has clearly defined duties and obligations within their scope of practice. They are encouraged and empowered to raise issues or concerns with respect to safety and quality with the appropriate health professional.

For example, a pharmacy assistant is to raise questions with the pharmacist who is responsible for directing and supervising the pharmacy assistant. Should a pharmacist have concerns, these would be raised with the prescribing physician.

As Laura identified through her earlier description of events, several pharmacy assistants were involved in

raising questions and escalating the issue internally with the DRCC pharmacist and supplier.

Peterborough Regional Health Centre is very proud of these alert and dedicated staff and all of our health professionals who are continually focused on safe, excellent quality care. We recently recognized these three staff members at a private ceremony at Peterborough Regional for doing what we call "a good catch."

I wish to reassure the committee that, as with all of our officials and staff at PRHC, they spoke openly, honestly and fully with Dr. Thiessen in his interviews. The hospital has been inundated with persistent and determined requests to recognize their contribution.

We have honoured their desire to remain private, as they have asked, allowing them the ability to focus on the important task of continuing to do their part in helping patients in their personal battles against cancer.

Finally, I would like to underline that PRHC supports the process set out by the independent expert panel under the leadership of Dr. Thiessen.

Also, it is important to acknowledge that objective assessments of incidents such as these in many industries normally point to multiple, successive failures in seemingly independent processes—not a failure of good people doing extraordinary work.

I am confident that I reflect the sentiment of all hospitals that we are anxious to understand the full set of circumstances involved in this unfortunate incident and put in place improvements that will ensure that it does not happen again.

Thank you for your attention. This concludes our formal statements. We would be pleased to answer questions from the members.

The Chair (Mr. Ernie Hardeman): Thank you very much for the presentation. We will start the questioning with Mr. Yurek.

Interjection.

The Chair (Mr. Ernie Hardeman): Oh, Ms. McKenna.

Mrs. Jane McKenna: Thank you very much. I'd like to thank you so much for coming here today. You should be very proud of your team, like you just said—all teamwork works together—and how grateful the people who were touched by this were that they came and did what they did. So thank you so much. It's wonderful.

My first question is, when did you start outsourcing the chemotherapy drug in question at Peterborough Regional Health Centre?

1620

Mr. Ken Tremblay: We get the drug through the Durham Regional Cancer Centre program, and it was part of that process that the product appeared. So this was not our decision to outsource. We are the site that receives materials.

Mrs. Jane McKenna: Okay. The contract, I'm assuming, is with Marchese and Medbuy, and not with you?

Mr. Ken Tremblay: That's correct.

Mrs. Jane McKenna: Okay. So did anybody at any time on your hospital staff review that contract?

Mr. Ken Tremblay: No, we weren't part of that process.

Mrs. Jane McKenna: Ms. Zaffiro was in here yesterday from Marchese, and she speculated yesterday that Baxter's drugs were concentration-specific, and she stated very clearly that the drugs provided by Marchese were not concentration-specific. She also said that Marchese's labels were approved by Medbuy. Please, can you explain how these two labels would look and how they would differ for a concentration-specific label and non-concentration-specific label?

Ms. Laura Freeman: As I explained before, the difference between the two labels was, in the Marchese, it stated that gemcitabine was four grams per 100 millilitres, and the Baxter label indicated 4,000 milligrams and went on to total volume of 105.26 millilitres, and labelled as gemcitabine 38 milligrams per millilitre. So the end concentration is on the Baxter bag.

Mrs. Jane McKenna: I guess my question is, if Medbuy had done the contract, put all the information in the contract, why would the chemotherapy that you were getting differ from one company to another? If it's the same—so do you know if it was the same contract that you had with Baxter, or was it changed for some reason?

Ms. Laura Freeman: We were not party to the contract, so we're not aware of that information and have no knowledge of the contracts in either case.

The Chair (Mr. Ernie Hardeman): Mr. Yurek.

Mr. Jeff Yurek: Thank you. I reiterate the competence of your staff. They all deserve a pat on the back for catching this and alerting Ontario to the error that had occurred.

I might go back—my question to start out is with the labelling. We've heard from other hospitals that Marchese won the contract—even Marchese announced—because they had superior labelling, yet what you've shown us is that Marchese had four grams in 100 ml only and Baxter seemed to have had more information on it. Would you agree with previous statements made that Marchese had the superior label?

Ms. Laura Freeman: We were not party to the contract or the evaluation, but we did the comparison on the labelling and the labelling was different between the two products.

Mr. Jeff Yurek: And do you know if the Baxter label that you received was consistent with what they provided the other hospitals in the province?

Ms. Laura Freeman: We don't know.

Mr. Jeff Yurek: Has your hospital been given any direction from the Ministry of Health as to how to work with Medbuy in procuring medications? Any standards or guidelines that you think that they should be following, through the Ministry of Health?

Mr. Ken Tremblay: Not to that degree. Medbuy, HealthPRO and all kinds of shared service organizations to improve the efficiency of the health care supply chain have been in our industry for a long time and, in fact,

through OntarioBuys and the Minister of Finance have been encouraged.

Mr. Jeff Yurek: Yes, the Minister of Finance. But even though this has been ongoing for many years, procurement of compounded medications, it's a growing field just mainly because the amount of staff time—your staff have better uses doing other things than spending hours and hours making certain medications. That's why most likely it gets sent outside of the hospital area. You would think the Ministry of Health would step in and perhaps say, "This is a very important field that we're now entering into, a new dimension in health care that maybe we should provide some guidance and protocol on." What are your thoughts on that?

Mr. Ken Tremblay: I think that's probably going to be at the heart of Dr. Thiessen's assessment of the situation, to give long-term recommendations to the sector or the industry as to how we might want to pursue this. In the past—this has been an issue for hospitals and health care for some time, and every hospital is a little bit different.

Mr. Jeff Yurek: Do you do any other medications compounded outside of the hospital that you receive? Any other classes of medication outside the chemo drugs?

Ms. Laura Freeman: Yes, we do.

Mr. Jeff Yurek: Can you list them for us and who supplies them?

Ms. Laura Freeman: I don't have the exact list available, but we can get that to the committee.

Mr. Jeff Yurek: Is it the same supplier, Baxter, Marchese—

Ms. Laura Freeman: It is with Baxter.

Mr. Jeff Yurek: Baxter supplies all those. Did Medbuy involve you at all in the process that's picking a new supplier when they decided to tender?

Ms. Laura Freeman: They did not. We are part—we receive our drugs through the Durham Regional Cancer Centre, so we're not part of that contract. It's through our relationship with the DRCC.

Mr. Jeff Yurek: Do you think it would be wise to maybe involve the participating hospitals and maybe the Ministry of Health in procuring compounded medications, or medications in general?

Ms. Laura Freeman: When there's group buying, oftentimes there are representative hospitals selected to do the evaluations, so it's not always every hospital that is participating that sits on evaluation committees. So that is standard practice.

Mr. Jeff Yurek: Do you have any knowledge of what pre-qualifications Medbuy would put out in order to allow someone to bid on a product or to produce a product?

Ms. Laura Freeman: We were not party to the whole process, so we do not have that knowledge.

Mr. Jeff Yurek: A general question I've asked others: Your blood products come from a certified, accredited source, your drugs come from accredited, certified manufacturers, and the hips you use in replacements come from qualified, certified, accredited organizations. Do you not think it would be common sense that your compounded medications also come from a certified, accredited source?

Mr. Ken Tremblay: I think, in the broader sense, that would be the goal of the system, yes.

Mr. Jeff Yurek: And do you not think perhaps that in the RFP tendering process, guidelines would have come from the Minister of Health to ensure that the company that is tendering the product is—

Interjection.

Mr. Jeff Yurek: Sorry, Bill?

Interjection.

Mr. Jeff Yurek: Okay—that the products are coming from an accredited supplier?

Mr. Ken Tremblay: The RFP process is guided by the broader public sector procurement guidelines through the shared services enterprise and these group purchasing enterprises. Those kinds of specifications are usually in the RFP. We don't know that because we weren't part of that one.

Mr. Jeff Yurek: Okay. When stuff changes in the system, that perhaps maybe the government needs to react, I always refer it back to the Internet. When the Internet came to the system, whole new policies and procedures had to be developed because it was something new and it was going to improve the system, much like outsourcing the compounded medications; it's something that's newer and it's going to hopefully improve the utilization of our health care professionals. I think a lot of that direction should have been thought of from one of the aspects of the Ministry of Health in bringing that forward.

I'll save my time for the next round.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Gélinas.

M^me^ France Gélinas: Thank you. I will continue on with what my colleague was saying. First, thank you for being here, and thank you for all of your team. I think, Doctor, you said it best: You were able to catch this because of the culture you have within your organizations, because everybody stepped up to the plate and felt comfortable bringing up issues. We can only thank you and, I guess, cannot thank you enough for what you have done and continue to do.

The chemo drugs come to you through a partnership that you've explained to us that you have with Durham. Basically, you feel confident in the relationship you have with Durham, that when they went out and used group purchasing, they had kind of done due diligence and what you were going to get was what you needed?

Dr. Peter McLaughlin: Yes, we do have confidence in the Durham Regional Cancer Centre.

M^me^ France Gélinas: I take it that, for you, this is a meaningful way to do business. It works good. I mean, you have the shared services with them. The physicians who actually go to your site came and testified earlier on, and it seems to be a good partnership.

1630

Dr. Peter McLaughlin: Yes, we agree with that.

M^me^ France Gélinas: And is this something that you figure should continue?

Dr. Peter McLaughlin: Yes. I think it's in the best interests of patient care in our region that it continue.

M^me^ France Gélinas: I agree.

We're in the midst of finding out how we can do better, how we can make sure it doesn't happen again, and the Ministry of Health sends this regulation that states that hospitals must not purchase drugs directly or indirectly from an unregulated facility. But you've explained to us that you do not really take part in the purchasing of those drugs; you trusted your partner. What would that mean for you, that from now on, you cannot purchase drugs directly or indirectly from an unregulated facility? You never had the need to go and check because you trusted your partner. But now we've added some checks and balances onto your hospital that do not respect a partnership that is there, that works, that provides quality care for the people of your region. How do we balance the two?

Dr. Peter McLaughlin: As I said, from the patient's perspective, this partnership has resulted in delivery of excellent care over the years. I look forward to Dr. Thiessen's report to recommend appropriate changes in our system to benefit all.

M^me^ France Gélinas: It's weird that we have a Ministry of Health that suddenly starts to issue directives that are not respectful of a process that has served the people of Ontario well. I agree with you that it would be wiser, from the Ministry of Health's perspective, to wait till the results are in rather than issue regulations that would basically force you to completely rework that partnership.

That brings me to this grey area of oversight. I'll ask any of you: Did you know that there was a grey area of oversight in medication preparation?

Mr. Ken Tremblay: No, we didn't.

M^me^ France Gélinas: When did you find out?

Mr. Ken Tremblay: During the course of this review and in the subsequent days following this event, as information became available through your proceedings and the like—more recently, even as of some of yesterday's testimony.

M^me^ France Gélinas: Were you surprised that there was a grey area of oversight?

Mr. Ken Tremblay: In hindsight, yes. I think we're going to look to Dr. Thiessen's recommendations to fill the void, whether it's by regulation or practice or professional performance etc. I don't think we would knowingly purchase from inauthentic sources.

M^me^ France Gélinas: Had you known, things would have been different?

Mr. Ken Tremblay: In hindsight, I think we want to make sure that all of our procurement processes meet the standards expected in the province of Ontario, as regulated—or by reviews such as this. Again, we look forward to Dr. Thiessen's in-depth analysis of the whole supply chain in this admixture area and the jurisdictional issues that will probably ensue.

M^me^ France Gélinas: I agree. Given what we know now—that it was a grey area of oversight, that that grey area of oversight had actually been identified quite a long time ago—does that make you nervous that there could be other grey areas of oversight within the partners that you depend on?

Mr. Ken Tremblay: I think we're relatively confident in the performance of the health system. We can always improve. It's a large system; it's very complex; it's filled with all kinds of regulations and processes and things like that. Again, we look forward to Dr. Thiessen, who's going to get into the nuances of this, so that on the specific issue about IV admixture and the marketplace, nobody's in that grey area.

M^me^ France Gélinas: If we look outside of drug supply—I mean, in order for you to do your work, you depend on not only drugs, you depend on results coming in from labs and X-rays and blood, all sorts of partners who are community-based partners but who send in vital information in order for the people who work in the hospital to do their work. Any worries there, that outside of drug procurement there could be other areas within the community-based sector that have no oversight?

Mr. Ken Tremblay: I think you're asking for some speculation, and I think we'd be hard pressed to indict any sector of the health industry, in all of its scale, in all of its nuances, in this country. We can always do better in any sector, so we'll be continually diligent and hope that our processes capture these.

M^me^ France Gélinas: Would I be paraphrasing correctly if I say that you basically trust the partners you work with, that there is sufficient oversight, that as complex as it is, the regulations and the oversight are there to allow you to trust your partners and to do your piece of the work?

Mr. Ken Tremblay: I would say yes, and that at its core for us on this episode, it was a good catch, just as it was supposed to do.

M^me^ France Gélinas: The system worked?

Mr. Ken Tremblay: From where we sit on this issue, yes.

M^me^ France Gélinas: I would say I agree. So there exists a grey area of oversight. You're not overly worried that other partners will come out the same way, because we take it for granted that the partners in the health care system do have oversight and that it was a one-off that it didn't happen this way.

How long has Peterborough been outsourcing drugs of any kind?

Ms. Laura Freeman: I'm not certain of the actual time frame of that, but we could check into that and get back to the committee.

M^me^ France Gélinas: Could I ask Ms. Weir if she would know?

The Chair (Mr. Ernie Hardeman): If Ms. Weir's going to answer, she'll need to come up and be sworn in before we get the answer.

Thank you very much, and the Clerk will ask you to either swear or affirm.

The Clerk of the Committee (Mr. William Short): What was your preference, Ms. Weir?

Ms. Brenda Weir: Affirm.

The Clerk of the Committee (Mr. William Short): So if you could just raise your right hand, please. Ms. Weir, do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Ms. Brenda Weir: I do.

The Clerk of the Committee (Mr. William Short): Thank you.

M^me^ France Gélinas: My question was, for how many years—how long ago did Peterborough start to outsource the procurement of some of their IV drugs?

Ms. Brenda Weir: We have had a contract with Baxter Civa since 2001.

M^me^ France Gélinas: Since 2001? Which drugs did it start with? Were you there at the time?

Ms. Brenda Weir: No, I was not there at the time.

M^me^ France Gélinas: Since you've been aware, have those contracts changed, grown? About how many different kinds of drugs do you subcontract out to Baxter?

Ms. Brenda Weir: I think there's about four classes of drugs on that list.

M^me^ France Gélinas: Okay. I think you already—you didn't, but your colleague testified that you still have a contract with Baxter.

Ms. Brenda Weir: We do.

M^me^ France Gélinas: Okay. It was solely the contract for those two chemo drugs that went to Marchese?

Ms. Brenda Weir: Those drugs are not within the Baxter contract.

M^me^ France Gélinas: Okay. You deal more specifically with pharmacy. Did you know that there was a grey area of oversight in the supply chain?

1640

Ms. Brenda Weir: No, I did not.

M^me^ France Gélinas: In your experience dealing with drugs that are given to you, IV drugs that are given to you, either by concentration or by full amount, is this something out of the ordinary or is this something you see every day?

Ms. Brenda Weir: I'm sorry; I'm not understanding.

M^me^ France Gélinas: The presentation that was done to us says the Marchese label indicated a total amount—there were four grams of the medication—as opposed to the Baxter's label that indicated a concentration of medication of 38 milligrams per millilitre. What I'm asking you is, those two ways of reporting drugs in an IV medication, is this something you see often?

Ms. Brenda Weir: You'd look for the final concentration of milligram per ml.

M^me^ France Gélinas: In all of the IV drugs that you deal with?

Ms. Brenda Weir: You would look for that, yes.

M^me^ France Gélinas: So for your pharmacy technician, it was—

Ms. Brenda Weir: Assistant.

M^me^ France Gélinas: Sorry. For your pharmacy assistant. What's the difference?

Ms. Brenda Weir: There's a regulation process that they're going through to become registered technicians.

M^me^ France Gélinas: So it was the pharmacy assistant?

Ms. Brenda Weir: Yes.

M^me^ France Gélinas: How big is your pharmacy department?

Ms. Brenda Weir: Staff-wise or—

M^me^ France Gélinas: Yes.

Ms. Brenda Weir: We have 10 pharmacists and about 46 pharmacy assistants and aides.

M^me^ France Gélinas: No technicians?

Ms. Brenda Weir: Not yet. They're in the process of regulating.

M^me^ France Gélinas: Okay, and what's the difference between an assistant and an aide?

Ms. Brenda Weir: An aide does more receiving or—they're not actually mixing the drugs.

M^me^ France Gélinas: Okay, the ones that are mixing the drugs—and of those 10 pharmacists and 46 assistants and aides—how many are, more specifically, for the cancer drugs?

Ms. Brenda Weir: There are four assistants that work with the oncology program.

M^me^ France Gélinas: And no pharmacists?

Ms. Brenda Weir: There are pharmacists but they are DRCC pharmacists.

M^me^ France Gélinas: Okay. So the pharmacists for your oncology programs are with your partner?

Ms. Brenda Weir: Yes.

M^me^ France Gélinas: And then you have four in-house assistants. Okay.

Since you're no longer using Marchese products, how are you dealing with those drugs now?

Ms. Brenda Weir: We're admixing in-house.

M^me^ France Gélinas: In-house in Durham or in-house in Peterborough?

Ms. Brenda Weir: No, in Peterborough.

M^me^ France Gélinas: And you're doing this patient-specific?

Ms. Brenda Weir: Yes.

M^me^ France Gélinas: Okay. The people in Peterborough, when they first saw that there was no concentration but just the total amount, why did it alert them?

Ms. Brenda Weir: Well, they were doing their double-checks to look at—that's what they do to mix their drugs: They have a double-check process.

M^me^ France Gélinas: And when they double-checked, they wanted to see a concentration and they could not find it? That's why they raised the alarm bell?

Ms. Brenda Weir: Yes.

M^me^ France Gélinas: Did you want to ask a question? Okay, go ahead.

Ms. Cindy Forster: Hello. Yesterday I asked a question, not knowing what kind of dosages of chemotherapy agents are for specific patients, whether or not a red flag should have been raised at Marchese with respect to the gemcitabine, is it, the four grams in 100 ml. So my question to them was, was that kind of—they said that they were not requested to prepare concentration-specific doses, and so I asked the question, you know, was four grams per 100 ml a usual single-patient dosage for one chemotherapy treatment? They responded by saying they prepared what they were asked to prepare. The point I was trying to get at was, is that four grams in 100 ml an average dosage for one treatment? Would that have raised a flag for the pharmacist at Marchese, or was it a larger dose than a patient would normally receive for one chemotherapy treatment?

Dr. Peter McLaughlin: I am not an oncologist, so I'm not going to comment on the range of doses of gemcitabine. What is clear in the one patient at Peterborough that we were dealing with: the dose to be given was less than the full bag.

Ms. Cindy Forster: Thank you. I think that was it.

M^me^ France Gélinas: Actually, I think I'm going to let it go around because the next line of questions are completely different.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Jaczek?

Ms. Helena Jaczek: Thank you, Chair. On behalf of the government, I'd also like to congratulate your pharmacy assistants for the great work they did in terms of noticing the difference in the labelling and being alert enough to take it further, take it up to the Durham Regional Cancer Centre. I think certainly patients in the Peterborough area can be quite reassured by that very prompt action. Thank you for the chronology as to what happened internally within your own system.

I guess I would say that in terms of notifying the Ministry of Health and Long-Term Care, since you are sort of a subsidiary to the Durham Regional Cancer Centre, I suppose any notification to the Central East LHIN or to the ministry, you would have assumed, was done by them. You didn't think to notify anyone March 20.

Mr. Ken Tremblay: Our notification went to DRCC and then there was a fan-out and a distribution. There's a well-connected network of the professions in these facilities and the word went out quickly and the verification was made—that fan-out—relatively quickly.

Ms. Helena Jaczek: We've been focusing in on the gemcitabine. What about the cyclophosphamide? I know that you put a hold on the use of it, but was that tested at all by your pharmacy assistants?

Ms. Laura Freeman: It was not. We had not depleted the previous supply of that drug, so we hadn't started in to and had not received a new supply.

Ms. Helena Jaczek: So you were still using the Baxter supply.

Ms. Laura Freeman: We were still using the Baxter product.

Ms. Helena Jaczek: In terms of your quality assurance process within your pharmacy, you obviously empower your people to ask questions and we heard quite a bit of that sort of culture from Lakeridge and from Kevin Empey as well, and that's wonderful. But do you have some sort of formal quality assurance process internally related to compounded drugs?

Ms. Brenda Weir: We do. We follow the Central East LHIN admixture guidelines.

Ms. Helena Jaczek: Could you elaborate on what those admixture guidelines are?

Ms. Brenda Weir: Those are guidelines that have been prepared with representatives from the hospital within the Central East LHIN, which they follow. They're based on best guidelines throughout Canada and the BC manual. There's about 20 references.

Ms. Helena Jaczek: Obviously, having discovered the problem with gemcitabine, you can say with confidence that you're happy with the safety of the drug supply provided through Peterborough regional hospital. Is that correct?

Dr. Peter McLaughlin: Yes.

Ms. Helena Jaczek: Thank you. I think part of what we have talked about in this committee is that our concern is for those patients out there. Just for the record, we want to reassure people, certainly in your area, that you have a good quality assurance program.

When Baxter was the recipient back in I think you said 2001, Ms. Weir, was Peterborough hospital involved at that time with that outsourcing?

Ms. Brenda Weir: Yes, and that would be outside of the oncology program.

Ms. Helena Jaczek: And at that time, you were using direct purchasing, or did you use Medbuy? Would you recall or would you know?

Ms. Brenda Weir: That would be through direct purchasing.

Ms. Helena Jaczek: It was through direct purchasing. So when the move came as part of Durham Regional Cancer Centre that they would look after the chemotherapeutic drugs, was there any consultation with Peterborough in terms of what that would look like? It sounds like you just trusted them to do the right thing.

Mr. Ken Tremblay: It's a bit of that. It's also the governance of a shared regional program through the memorandum that exists in the cancer care model, that you have a regional centre and then organizations that support it through the management of patients and all those things. The MOU contemplates a variety of responsibilities for both parties, and on this particular side, it's the provision of supplies, which, in this case, would include those drugs. Other things—miscellaneous expenses, med-cert supplies—would be covered in other parts of normal operations.

1650

Ms. Helena Jaczek: I'm going to just turn to the grey area. Ken, you and I have been around Ministry of Health people for longer than we both choose to remember, probably. You've said that you did not know this was a

grey zone. Do you ever remember, in your many dealings with the ministry, any sort of conversations around the subject of compounded drugs and regulation, accreditation or anything like that?

Mr. Ken Tremblay: Well, actually, Accreditation Canada contemplates that best practice is—especially for those sites that might have low volumes—to contemplate outsourcing for quality assurance, because it's small doses and small sites with little infrastructure or capacity to put some of these very complex medication series together—that actually contemplates as an accreditation standard that that in fact be the direction. All the parties of the health system are part of the formation of accreditation guidelines, so I'm sure we were all aware of that. The notion of a regulatory grey zone is new.

Ms. Helena Jaczek: Is new?

Mr. Ken Tremblay: Yes.

Ms. Helena Jaczek: So you were never party to conversations related to that.

Mr. Ken Tremblay: No.

Ms. Helena Jaczek: So now that you have heard, as we've all heard, that there is this grey zone between Health Canada and the College of Pharmacists, do you feel that the government's actions to date are reassuring in terms of the regulation that is proposed—the formation of the working group and Dr. Thiessen's review?

Mr. Ken Tremblay: The regulation is out for consultation in the broader system to make sure that it's applicable to all sites and settings. As you can imagine, there's quite a broad range of practice out there, so one regulation that meets all the needs of all the users in all the settings all of the time would be a challenge.

Dr. Thiessen et al. will obviously give advice and counsel on the regulatory framework, the jurisdictional overlap or gaps as they might exist, in order to safeguard the supply chain and admixtures. We look forward to that work. I think it's necessary work. And if it is a grey zone, then we should turn it to black and white and understand those accountabilities and responsibilities.

Ms. Helena Jaczek: Have you been a part of the working group that the ministry put together?

Mr. Ken Tremblay: I am on that working group, and we were one of the first sites that Dr. Thiessen visited to sort of get a good grounding on how this issue emerged, evolved and morphed over time.

Ms. Helena Jaczek: And are you finding that dialogue helpful and useful?

Mr. Ken Tremblay: I think it's, among the four sites, making sure that we're all concentrating on the public and the patients affected, giving advice and counsel in terms of process. The regulation is a good start, but I think it will be finessed by Dr. Thiessen's advice and counsel and the broader consultations of the system.

This is a large piece of the Canadian health care system. We want to make sure that all of its pieces are embraced in it, because there could be parts that create gaps somewhere else, duplications somewhere else or another kind of issue unintentionally.

Ms. Helena Jaczek: Yes.

We'll save the rest of our time.

The Chair (Mr. Ernie Hardeman): Thank you. Ms. McKenna?

Mrs. Jane McKenna: Yes. My first question is, were you concerned about the gap that clearly was evident? We had, again, Ms. Zaffiro from Marchese here yesterday, and she said that when she was awarded the RFP, she clearly got on the phone—it was documented today that her facts were true—with the College of Pharmacists and also with Health Canada, asking to be regulated, because she was going to separate that part of her company because of this RFP that she had won.

This woman clearly realized there was a problem and picked up the phone to find out how she could be on top of it. Was there any time at all that you were concerned about the gap, and if you were, did you talk to the Minister of Health and Long-Term Care? That, to me, would be a red flag.

Mr. Ken Tremblay: We all, as a system, found that out yesterday, so I don't think we want to speculate on that. The conversation on what happened would certainly not be at our level in the system.

Mrs. Jane McKenna: Okay. Just as the CEO of a hospital, though, I guess that's—just listening to everything that's been going on here and sitting here on this committee, I guess another question I have is, who gives the direction to Medbuy to do the contract?

Mr. Ken Tremblay: The Medbuy buying group would give that direction based on those hospitals participating that would see the advantages of a collective RFP or bidding process. In this case, it was, I gather, four, and they chose to go to market with that product and volume as a discrete project. And we weren't part of that, so—

Mrs. Jane McKenna: So there's no oversight from you at all. When that contract gets put together from Medbuy—which is a broker; it's not a pharmacist or a hospital. They do that themselves. So they're solely responsible?

Mr. Ken Tremblay: They are the sponsor of that cancer program in our region.

Mrs. Jane McKenna: Okay. Go ahead.

The Chair (Mr. Ernie Hardeman): Mr. Yurek.

Mr. Jeff Yurek: So your relationship with Medbuy is basically—

Mr. Ken Tremblay: We don't have a relationship with Medbuy.

Mr. Jeff Yurek: You don't have any relationship. So Durham regional coordinates the purchases through Medbuy for you; is that—

Mr. Ken Tremblay: I'll maybe let Laura talk to that, but they issued that process.

Ms. Laura Freeman: That's correct. Durham Regional Cancer Centre does the procurement of our chemotherapy drugs.

Mr. Jeff Yurek: So they do it for your hospital and others in the group?

Ms. Laura Freeman: I assume so.

Mr. Jeff Yurek: So why would you have to use Medbuy, then, at all? If already a group of hospitals have come together to coordinate procurement, why couldn't

Durham regional deal directly with Baxter or Marchese to come to some sort of contract?

Ms. Laura Freeman: Durham would have to answer that question because the procurement of the chemotherapy is through them.

Mr. Jeff Yurek: I was just thinking why—was there a need to actually use Medbuy at all in that service? Couldn't it have been handled by the group of pharmacies themselves—

Mr. Ken Tremblay: The Canadian public enjoys volume discounting through supply chain strategies, in many cases underwritten by the provincial governments. So whether it's Medbuy, HealthPRO or other shared service organizations that precede it, economies of scale by collective action benefit the price point of various products in the system. So that's how these HealthPROs and Medbuys were created.

Mr. Jeff Yurek: I've heard the LHIN mentioned a few times, but no one has yet to give me an answer. What role does the LHIN have in any of this situation?

Mr. Ken Tremblay: You'd have to check the details of their legislation, but largely it's funding and oversight at the macro level.

Mr. Jeff Yurek: So the oversight—

Mr. Ken Tremblay: General operations, not detailed—so system planning, capacity, distribution, population health, those kinds of issues.

Mr. Jeff Yurek: So they weren't really involved at all with this problem?

Mr. Ken Tremblay: No.

Mr. Jeff Yurek: Would you be in favour of allowing the OCP to regulate and oversee your hospital pharmacies?

Interjection: They do already.

Mr. Jeff Yurek: In-hospital, not the outpatient pharmacies.

Dr. Peter McLaughlin: If that's the wisdom of the policy-makers, we will be happy to accept it.

Mr. Jeff Yurek: Just your opinion. It won't be held against you.

Dr. Peter McLaughlin: This is a complex area. It would be presumptuous of me to name any body that would be better than any other body to do the job that needs to be done, and I would hope that Dr. Thiessen would make a recommendation that would inform us on the best regulation. But again, from clinicians on the ground, we welcome good regulation, and our job is to have the policies and procedures that will support that regulation to do the job that needs to be done for the patients.

Mr. Jeff Yurek: I just asked that because, right now, even hospital pharmacists don't really have to be associated with the College of Pharmacists if they choose not to, unless they go and work out in the community or do something else. There's talk about bringing hospital pharmacists under the College of Pharmacists, and now you have perhaps a college of pharmacy following hospital policy and an Ontario college of pharmacy policy, and the two are going to maybe bump heads some time down the road, so I'm looking out to the future. Who's going to supersede who? At the end of the day that would be the question to throw out there.

Dr. Peter McLaughlin: I would say that's a very good question and there are people wiser than me that will be able to answer that as this goes ahead, I'm sure.

1700

Mr. Jeff Yurek: I'll save my time for the next time around.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much. You have about two minutes.

Ms. Gélinas?

M^me^ France Gélinas: I think my question will be for you again, Mrs. Weir. I'm curious to see—on March 20, at 2:20, a pharmacy assistant notices a difference. You must have had patient appointments booked for the rest of that day. Cancer treatment programs tend to be pretty busy until the end of the shift. Do you know if anybody had a missed appointment, as in you had run out of the Baxter drug, you start the new supplier, and you find yourself having to cancel appointments or to reschedule?

Ms. Brenda Weir: There were no cancelled appointments.

M^me^ France Gélinas: There were no cancelled appointments.

In your hospital, only one person was found to have received one of the two drugs. Am I right?

Ms. Brenda Weir: Yes.

M^me^ France Gélinas: And that person was notified, you've already told us.

Two things. The first one is, except for chemotherapy drugs and cardiac drugs, do you usually deal in concentration of medication, or do you usually deal in actual amount?

Ms. Brenda Weir: It's concentration.

M^me^ France Gélinas: It's concentration all the time?

Ms. Brenda Weir: Concentration.

M^me^ France Gélinas: So the people who work in your pharmacy know to look for the concentration of the medication on the different IV bags that they get.

Ms. Brenda Weir: Yes.

M^me^ France Gélinas: And that's not only for cancer and cardiac; it would be for other IV drugs as well?

Ms. Brenda Weir: Concentration.

M^me^ France Gélinas: Even if you were to give a prescription for antibiotics, it would be by concentration?

Ms. Brenda Weir: Are you talking about injection or—

M^me^ France Gélinas: Drip—I'm talking IV.

Ms. Brenda Weir: It's usually by concentration.

M^me^ France Gélinas: By concentration. Okay.

It looked like you wanted to add something.

Dr. Peter McLaughlin: From the physician's point of view, the total amount of drug would be prescribed. The administration through the formulary would then rely on nursing and concentrations to achieve that total dose in a reasonable volume.

M^me^ France Gélinas: Okay, so you basically always, though, deal with concentration at your end. At the

doctor's end, he wants a certain amount, and then at the pharmacy end they use the concentration in the right amount of liquid to make sure that they meet whatever the prescription was.

Dr. Peter McLaughlin: That is correct.

The Chair (Mr. Ernie Hardeman): Thank you very much. That does conclude your time.

Ms. Jaczek.

Ms. Helena Jaczek: How much time do we have?

The Chair (Mr. Ernie Hardeman): Nine minutes.

Ms. Helena Jaczek: Excellent.

We're fairly confident now, with Health Canada involved, the college of pharmacists of Ontario and Dr. Thiessen's report and so on, that this grey zone is no longer going to be grey. There will be regulation. Those companies involved in compounding will be regulated etc.

I would like to ask a little bit more about outsourcing. Ken, again, in your experience, what are the benefits of outsourcing in general? You've alluded to economies of scale. Can you just sort of give us more on that?

Mr. Ken Tremblay: The theory and practice of outsourcing 101 is largely to achieve economies of scale or to get some additional benefit, either through that scale or infrastructure. This chemo issue was done in a semi-sterile technique: fume hoods, very expensive infrastructure, very highly trained individuals that need sufficient volume to maintain their skills and proficiency. There's technology involved that has to be maintained, software etc. So when you are faced with some threshold volume, you decide whether, in the overall cost-benefit, risk-reward clinical management—you try to make those decisions. We put those people in a room together and we ask them to evaluate these various scenarios, and that ultimately culminates in a recommendation to either insource or outsource. It varies all the way from information technology to utilities to consumables and, in this case, admixtures. Every large organization, I think, goes through that decision tree.

Ms. Helena Jaczek: I know my colleague wants to ask a question, but I just want to follow up with what you said. So you don't see in the future, because of this particular incident, that you're going to back off in general related to outsourcing?

Mr. Ken Tremblay: We will continue to use the diligence necessary to make those decisions in the best interests of patient care, efficiency, economy, safeguards, critical mass and a variety of other criteria. We are under incredible pressure as a health care system to make the tax dollars go further and, where we can, to get those savings passed on to either capacity or new programming as Ontario grows. So from a theoretical perspective, no, this is not a deal-breaker, but it certainly widens our eyes in terms of the nuances and the issues associated with this decision.

Ms. Helena Jaczek: Mr. Mauro.

The Chair (Mr. Ernie Hardeman): Thank you very much. Mr. Mauro?

Mr. Bill Mauro: Thank you, Mr. Chair. I've been subbed on this committee; I'm playing a bit of catch-up here. Ms. Weir, you said that in 2001 the contract came into place with Baxter. Is that accurate?

Ms. Brenda Weir: Baxter CIVA, yes.

Mr. Bill Mauro: And previous to that, Peterborough directly procured that product?

Ms. Brenda Weir: I don't know. I wasn't employed at Peterborough at that time.

Mr. Bill Mauro: Is there anybody who would know the answer?

Mr. Ken Tremblay: No.

Mr. Bill Mauro: So we don't know?

Mr. Ken Tremblay: We don't know.

Mr. Bill Mauro: Okay. I was interested in your answer earlier, Mr. Tremblay, when there was a question for you from the third party about outsourcing. In your case, Durham Regional Cancer Centre procures the product for you. I thought it was interesting: You kind of turned the argument on its ear a bit and made it sound like there are many examples, especially for smaller hospitals—I come from northern Ontario and we have a number of smaller hospitals relative to what we might find in the GTA—where the outsourcing to an organization like Durham Regional Cancer Centre, or we have a very robust cancer centre in my hospital in Thunder Bay, could actually lead to an enhanced level of accountability and quality assurance. I think that's what you said; that was your point. Is that fair of me to say?

Mr. Ken Tremblay: Yes.

Mr. Bill Mauro: The point being that many small hospitals don't have the time, the staff, the expertise necessary to provide quality assurance for a variety—in this case, we're talking about the chemotherapy drugs. I would assume there would be other examples that, as a hospital professional, you could probably give us where it actually provides a safer system for the patient and a better sense of safety for the hospitals themselves.

Mr. Ken Tremblay: Our industry tends to work on the adage that the more you do, the better you get. It's a critical mass issue, that at certain thresholds of volume there's a better likelihood of a good result because you do so many. We have to always look at the competencies, the skills, the volumes necessary to maintain that proficiency and to safeguard that in the interest of clinical care and all the other variables.

Mr. Bill Mauro: So with the Durham Regional Cancer Centre, which was procuring the chemotherapy drugs, this was a publicly funded organization with specialized skill sets that was procuring chemo drugs for a variety of health care providers?

Mr. Ken Tremblay: Through their contracts and their own group purchasing strategies, either Plexxus or Medbuy.

Mr. Bill Mauro: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. Ms. Jaczek?

Ms. Helena Jaczek: Yes. How are you preparing these products now or how are you acquiring them?

Ms. Brenda Weir: They're actually being admixed in the hospital right now.

Ms. Helena Jaczek: So they're being admixed in your hospital.

Ms. Brenda Weir: Yes.

Ms. Helena Jaczek: Not Durham; right there. Are you finding it a very time-consuming process, or how—what's the difference now?

Ms. Brenda Weir: They're building it into their day-to-day activities in the area.

Ms. Helena Jaczek: So you haven't had to hire more staff?

Ms. Brenda Weir: No.

Ms. Helena Jaczek: You're able to cope with the volume that you have.

Ms. Brenda Weir: Yes.

Ms. Helena Jaczek: And you have a pharmacist overseeing the admixing?

Ms. Brenda Weir: There's a pharmacist there for consultation, yes.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you, and that's complete. Mr. Yurek, if you have nothing further, thank you very much—

Interjection.

The Chair (Mr. Ernie Hardeman): You have a comment, Ms. Gélinas?

M^me^ France Gélinas: No. I was hoping to be able to use some of the time. Those people travelled a long way. I might as well talk to them while they're here.

The Chair (Mr. Ernie Hardeman): Well, that would have to be unanimous consent from the committee, because the times are pretty strictly set here.

M^me^ France Gélinas: It would be a very short question.

The Chair (Mr. Ernie Hardeman): Do you we have unanimous consent to have another question? Mr. Yurek, you have two minutes left.

M^me^ France Gélinas: You're willing to share your two minutes with me?

Mr. Jeff Yurek: If the government agrees, sure.

The Chair (Mr. Ernie Hardeman): Okay. We'll allow the question.

M^me^ France Gélinas: One question, and it shouldn't be a too hard one. You were the one least impacted, if you look at the number of patients. You testified that you only had one patient who received a diluted amount of drugs. My question is, although the facts are there, that there was only one patient, have you noticed an impact on the rest of the oncology patients? Have you noticed an impact on the rest of the people who you help in your hospital?

Dr. Peter McLaughlin: In our hospital, and amongst our staff, I would say there's a sense of pride about the pharmacy staff. I would have concern, as a physician, that this entire incident province-wide would raise concerns among patients, patient groups as a whole, about the pharma agents that they are getting. I think that's why it's important to complete Dr. Thiessen's review to change our system in whatever way makes sense, to assure our entire public that our drug delivery system is as safe as it can possibly be.

The Chair (Mr. Ernie Hardeman): Thank you very much. It does conclude the time and the inquisition.

With that, the committee will reconvene at 2 o'clock on Monday. With that, the committee is adjourned.

The committee adjourned at 1712.

CONTENTS

Tuesday 30 April 2013

STANDING COMMITTEE ON SOCIAL POLICY

Chair / Président
Mr. Ernie Hardeman (Oxford PC)

Vice-Chair / Vice-Président
Mr. Ted Chudleigh (Halton PC)

Mr. Lorenzo Berardinetti (Scarborough Southwest / Scarborough-Sud-Ouest L)
Ms. Margarett R. Best (Scarborough–Guildwood L)
Mr. Ted Chudleigh (Halton PC)
Ms. Cheri DiNovo (Parkdale–High Park ND)
Mr. Ernie Hardeman (Oxford PC)
Ms. Helena Jaczek (Oak Ridges–Markham L)
Mrs. Amrit Mangat (Mississauga–Brampton South / Mississauga–Brampton-Sud L)
Mr. Michael Mantha (Algoma–Manitoulin ND)
Ms. Jane McKenna (Burlington PC)

Substitutions / Membres remplaçants
Mr. Grant Crack (Glengarry–Prescott–Russell L)
Ms. Cindy Forster (Welland ND)
M^{me} France Gélinas (Nickel Belt ND)
Mr. Bill Mauro (Thunder Bay–Atikokan L)
Mr. Jeff Yurek (Elgin–Middlesex–London PC)

Clerk / Greffier
Mr. William Short

Staff / Personnel
Ms. Elaine Campbell, research officer,
Legislative Research Service